PHILADELPHIA, FEBRUARY 21, 1885.

ORIGINAL LECTURES.

CLINICAL LECTURE ON EMPHYSEMA AND EMPYEMA.

BY FRANCIS DELAFIELD, M.D.,

Professor of Pathology and Practice of Medicine in the College of Physicians and Surgeons, New York.

EMPHYSEMA.

GENTLEMEN,—We have here a man 57 years of age, a painter by occupation, who tells us that he was perfectly well, and accustomed to work regularly at his trade, until last spring. At that time he began to have what he calls rheumatism, affecting especially the muscles of the back. At all events, he had pains affecting the muscles of the back, which have continued and become worse up to the present time. In spite of these pains, however, the man was able to work until about three months ago. He then began to have a cough, accompanied by mucous expectoration. The attacks of coughing are attended with some difficulty in breathing, but, except for the difficulty of breathing during the act of coughing, he says nothing about dyspnœa. He cannot go up-stairs very well, but he does not complain of bad breathing-power. He also has to sit up in bed at night, on account of pains in the back, but not because of trouble in respiration. He has lost some in flesh and strength, and during the three months this cough has existed he has been unable to work.

On examination, we find that he is somewhat emaciated, that his muscles are rather flabby. He is constantly coughing and clearing his throat, as if there were an excess of mucus in the larynx, trachea, and bronchi. On examination of the chest, we obtain the physical signs of emphysema and of bronchitis extending down into the smaller tubes. But you will notice that even after the exertion of taking off his clothing he is not breathing with any great effort. He breathes perfectly quietly, without any undue exertion of the muscles of respiration. His heart is apparently normal.

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Again, you will notice that at the present time the man has well-marked physical signs of emphysema, so well marked that the lesion must have been in existence for a considerable length of time,—much longer, probably, than three months. The ordinary descriptions of emphysema in the text-books, and the ordinary causes which are given for the production of the affection, are, I think, apt to mislead us as regards the real nature of the disease. We get too much in the way of looking at it as if it were a condition due to mechanical causes, as if the dilatation of the air-vesicles were the result of some mechanical interference with the function of respiration. We get in the habit, when we look at a patient suffering from emphysema, of thinking that he must have had a chronic bronchitis for a good while before he had emphysema, and that the emphysema was the result of the chronic bronchitis. We also have the old tradition handed down from one book to another, that persons who play on wind-instruments, or who forcibly exert the lungs in any way, are especially apt to have emphysema, the fact of the matter being that in most cases of emphysema which we see there has been no such cause of the disease at all. But they really present themselves as patients with chronic changes in the lungs occurring as a primary condition, and not as the result of

CHOLERA-PRECAUTIONS.—The dread of cholera, and the obvious necessity of taking all possible precautions against its introduction and—more fearful still—against its spread, have opened the eyes of the Viennese to a number of sanitary defects in their midst. A writer in the *Allgemeine Wiener Med. Zeitung* draws attention to the want of proper closet-accommodation, and calls upon the Stadtphysikat and all other sanitary authorities to see that there is proper provision of closed closets in all houses, and especially in public places, hotels, coffee-houses, schools, railway-stations, theatres, and generally wherever people congregate. He complains, and with truth, that accommodation in this direction is insufficient, and that the condition of the discharge-pipes in even much-frequented hotels is a deplorable one,—offensive to the guests, and dangerous to the health of the inmates. Let us hope and *make sure* that all our own closet arrangements are perfect.—*Medical Press.*

DISPOSAL OF REFUSE IN VIENNA.—One of the most important innovations during the year is the new method that has been adopted in Vienna of collecting and removing town refuse. In place of doing this in open carts as heretofore, and as, alas! is the custom in many English towns, each household is supplied with a barrel with a close-fitting lid. When this is filled, the lid is well fastened on, the barrel placed on the cart and removed to the place appointed, without the possibility of any household dust and filth, impregnated with disease-germs, being blown about, and possibly disseminating disease along the line of route. One would think that all sanitary authorities would at once take the hint and do likewise; but the ways of sanitary authorities are not our ways, nor their thoughts our thoughts.—*Medical Press.*

MISCELLANY.

ANNUAL REPORT OF THE NATIONAL BOARD OF HEALTH.—The report of the Board was presented to Congress February 2. It especially considered the history of Asiatic cholera in this country, and urged the importance of making investigations into the nature of the disease, its mode of communication, methods of introduction, and its clinical history. An appropriation of forty-three thousand dollars was asked for to carry on this work by the National Board, and it was further recommended that half a million dollars be appropriated to assist State and local boards in preventing the introduction and the spread of infectious diseases.

THE HEALTH OF CINCINNATI.—We are indebted to the health-officer of Cincinnati, Mr. C. W. Rowland, for the following figures, which controvert statements which have appeared in our pages and elsewhere as to the bad sanitary condition of the city and the unusual prevalence of epidemic disease. It is positively declared that the sanitary condition of Cincinnati was never better than it has been this winter, and scarlatina and diphtheria have not prevailed epidemically. During November, 1884, the total number of deaths from the former was only ten, and from the latter only six, and both diseases were distributed as to locality. Total deaths from diphtheria in 1884 were seventy-two, from scarlatina sixty-four. The following will give the mortality for the preceding years:

	Diphtheria.	Scarlatina.
1883	78	201
1882	118	336
1881	105	60
1880	103	134
1879	152	546
1878	156	435

These records are open to the public. They show, contrary to the general belief, that the health of the city was unusually good last year, notwithstanding recognized sanitary defects. The total number of deaths in 1884 was 5667; in 1883, 5916; in 1882, 6873; and in 1881, 6101.

OFFICIAL LIST

OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT U.S. ARMY FROM JANUARY 18, 1885, *TO JANUARY* 31, 1885.

PROMOTIONS.

LIEUTENANT-COLONEL JOHN E. SUMMERS, SURGEON.—To be Surgeon, with rank of Colonel. January 9, 1885.

MAJOR JOS. R. SMITH, SURGEON.—To be Surgeon, with rank of Lieutenant-Colonel. January 9, 1885.

CAPTAIN EGON A. KOERPER, ASSISTANT-SURGEON.—To be Surgeon, with rank of Major. January 9, 1885.

APPOINTMENT.

HENRY I. RAYMOND.—To be Assistant-Surgeon, with rank of First-Lieutenant. January 12, 1885.

WEBSTER, WARREN, MAJOR AND SURGEON.—Granted leave of absence for one year, on surgeon's certificate of disability. S. O. 20, A. G. O., January 24, 1885.

TREMAINE, W. S., MAJOR AND SURGEON.—Granted leave of absence for one year, on surgeon's certificate of disability. S. O. 14, A. G. O., January 17, 1885.

MAUS, LOUIS M., CAPTAIN AND ASSISTANT-SURGEON.—Granted leave of absence for two months, on surgeon's certificate of disability, with permission to leave the Division of the Missouri. S. O. 16, A. G. O., January 20, 1885.

TAYLOR, B. D., CAPTAIN AND ASSISTANT-SURGEON.—Granted leave of absence for one month, to take effect between March 15 and April 1, 1885, with permission to leave Department limits. S. O. 10, Department of Texas, January 26, 1885.

STEPHENSON, WM., FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—Relieved from duty at Fort Omaha, Neb., and ordered to Fort Niobrara, Neb., for duty. S. O. 6, Department of the Platte, January 19, 1885.

KEAN, J. R., FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—Ordered for duty in Department of Missouri. S. O. 23, A. G. O., January 28, 1885.

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chronic bronchitis, nor as the result of excessive or forcible expiration or inspiration; not as the result of playing on wind-instruments, but as the result of chronic textural changes in the lungs which resemble very much the chronic textural changes in chronic Bright's disease or in cirrhosis of the liver. The change seems to be more analogous to chronic inflammation than to anything else. When a person is suffering from such changes within the lung, he may or may not develop bronchitis. He may never develop bronchitis; he may die of emphysematous lungs without having had bronchitis at any time. But he is much more likely, some time or other, to have bronchitis.

Still further, you will notice in this man that, although there is well-marked emphysema and bronchitis, yet there is no asthmatic breathing. This man, you would suppose, is in a very favorable way of developing asthmatic breathing, because he has not only emphysema, but he has also chronic bronchitis; yet he has not asthmatic breathing, nor has he any of that constant dyspnœa which we see in so many cases of emphysema. The man breathes imperfectly, it is true, but it does not trouble him; he makes no effort to overcome it. The muscles of respiration move less rather than more than in well persons.

In a man of his age, suffering from emphysema and bronchitis, one of the first things to which we give our attention is an examination of the urine, to learn whether there are any signs of changes in the kidneys. This man's urine contains no albumen, and is of normal specific gravity. If we should find albumen even in small quantity, or low specific gravity of the urine, or an increased amount of the fluid, we should suppose that the man had a chronic interstitial nephritis of the atrophic variety, for this is a very commonly associated condition of emphysema. If the patient do not present any evidence of kidney-trouble, the prognosis is a great deal better.

The next question in this man's case is, what is the best treatment for him? His disease is bad enough to have disabled him from work for three months, and the kind of treatment which he shall receive is a matter of a good deal of importance to him. The man's circumstances are such that it would be impossible for him to go to another climate, and we shall have to do the best we can for him while he remains here. In the first place, it would be a very good thing for him indeed if he could go into a hospital, for this reason: inasmuch as he cannot go away to a different climate, it would be a great deal better for him to stay in the house all the time, not to go out of doors at all; and, that being true, it would be a great deal better for him to remain in a large building, like a hospital, with large rooms, than to remain in a small building with small rooms.

In the second place, we should have to give him certain drugs. He says he has been taking a variety of patent medicines, concerning the nature of which I am ignorant. I should be disposed to begin the treatment with the ordinary mixture of belladonna, ipecac, Dover's powder, and quinine. I should give him the following pill, which I am much in the habit of prescribing:

℞ Ext. belladon., gr. $\frac{1}{40}$;
Pulv. ipecac. comp., gr. $\frac{1}{10}$;
Pulv. ipecac., gr. $\frac{1}{10}$;
Quininæ sulphat., gr. $\frac{1}{2}$. M.

He would take one small pill of this kind every two hours during the day, and through the night when he woke. He might continue to take them for a week. I should expect that at the end of that time his cough would be better, that the expectoration of mucus would be diminished in amount, that his appetite would come back, and he would feel stronger. If this were true, at the end of the week I should give up the use of this remedy altogether, and give the patient one of the mineral acids, very likely combining it with the iodide of potassium, so that he should take, for example, five grains of the iodide of potassium and ten or fifteen drops of dilute nitric acid, with water and glycerin, or with some syrup, three or four times a day, for a considerable length of time.

EMPYEMA.

Some of you will remember having seen this young man once before, although it is a considerable length of time since he was here. He says it was the 10th of October, 1883, that he first came here. He was then suffering from well-marked empyema affecting the left side of the chest. He was sent to Roosevelt Hospital, and there

operated upon for empyema by making two openings into the chest-cavity, one behind and the other in front, passing a drainage-tube through from one opening to the other. After the chest was treated in this way he improved, and finally left the hospital apparently entirely well. His stay in the hospital was from October, 1883, to February, 1884. He remained well until about six weeks ago, when he began to have trouble again; his breathing began to grow short, and his side to pain him. He says a sort of boil formed at the seat of the former opening, and when it was opened he again began to breathe more easily.

The boy, as you see, is not emaciated. The two sides of the chest anteriorly are nearly symmetrical. As he breathes, however, you will observe that the right side moves more markedly than the left, although the latter does move in some degree. You observe where the so-called boil was opened. The resonance is good under the clavicle on both sides of the chest, but on the left as we descend it assumes a tympanitic character, and finally becomes flat. The breathing is normal over the right side of the chest in front. The heart is beating too rapidly, but it is nearly in its normal position, and there are no abnormal sounds. When he was still suffering from empyema the heart was pushed to the right, and the anterior opening which was made in the location which you observe gave no trouble; but as the boy began to grow better, and the heart to resume its normal position, it came in such close proximity to the drainage-tube at the anterior opening that more or less trouble was experienced.

From a posterior view the right side of the chest appears to be considerably larger than the left, and there is a slight curvature of the spine towards the retracted side. Here we observe two scars, one of which was the result of the posterior opening into the chest, and the other, which is lower, arose from an accident which sometimes occurs during this operation. The opening into the pleural cavity was made by degrees, and when the cavity was reached air and pus escaped forcibly, the air having reached the pleural cavity through a perforation by the pus into the lung. Some of the pus and air, instead of escaping directly outward through the opening, infiltrated between the planes of the muscles, and in this way the skin for some little distance became raised from the underlying tissue. The result of this was that for seven weeks there was considerable suppurative inflammation of the connective tissue, which gave no small amount of trouble. The second opening which you see was made to give exit to the pent-up pus between the skin and tissues beneath.

The resonance over the right side of the chest behind is exaggerated, while over the left side there is flatness below and absent respiratory sounds, but above the breathing is fairly good.

What happened in this boy's case is, that after the pus within the pleural cavity had escaped and ceased to form anew, the artificial openings healed up, the heart returned to its normal position, the boy gained in flesh and strength, and the lung expanded to a very considerable degree. But here the reparative process came to a stand-still. The lower lobe of the left lung did not expand, but has remained contracted, non-aerated. The extensive pleuritic adhesions and thickening caused retraction of the chest-walls. If the boy's condition had continued as it was up to six weeks ago, we should have regarded the case as giving a very satisfactory result after the treatment of empyema; but six weeks ago he began to have a suppurative inflammation in the left side of the chest below. It was not a recurrence of the empyema, properly speaking, because there remained no pleural cavity within which pus could form. At that locality there is nothing but collapsed lung, a mass of thickened pleura, and new connective tissue, and it is in this new tissue that the suppurative process has taken place.

What is to be done for the boy evidently is, to treat the local suppuration as we would treat a local suppuration or fistulous tract in any other part of the body. In the first place, the external opening must be made sufficiently large to allow the pus to escape freely, so that it will not accumulate and burrow in different directions. Then the tract of the sinus should be injected with such stimulating substances as would change the character of the tissue lining the suppurative tract and give rise to a granulation-tissue which would cause it to fill up. To enlarge the opening I should be disposed, first, to simply dilate it by means of a sponge or

laminaria tent, rather than proceed at once to make any incision with the knife. I should then explore the tract with the sound, to see how deep it was and to where it leads, and afterwards make the stimulating injections.

There is one feature in the case which I was unwilling to speak about while the boy was present; that is, the urine now contains a little albumen. When he was under treatment before, the urine was normal. A little albumen in the urine in a boy with such a history points very strongly indeed towards the formation of chronic diffuse nephritis, in which there is waxy infiltration of the Malpighian tufts.

ORIGINAL COMMUNICATIONS.

SPASMODIC TABES DORSALIS.*

Read before the Philadelphia County Medical Society, January 28, 1885,

BY JOHN M. KEATING, M.D.

AN interesting article appears in the *Revue mensuelle des Maladies de l'Enfance*, December, 1884, by Dr. d'Heilly, on "Spasmodic Tabes Dorsalis," relating three cases, from which we gather the following valuable points by literal translation:

About 1875, Prof. Charcot separated from the group of chronic myelitis an affection described as *spasmodic* tabes dorsalis, which was about the same time written upon by Erb under the name of spastic paralysis. It is a chronic affection characterized by slow and gradual progression, without doubt of spinal origin, with a paresis of the lower extremities, muscular contraction, and with spasmodic tremors either occurring when the limbs are touched or movements attempted, or else spontaneously. There is also increased tendon reflex.

It is most frequent in adults, but Erb, Seeligmuller (*Progrès Médical*, 1876), d'Espine, and Picot have recorded a number of cases in children. In these cases motion alone is affected; sensibility remains throughout normal. The disease may begin early,—at eight months in one case of the three reported, at two and one-half years in another. Ordinarily it is first found out by the mother, who finds difficulty in flexing the knees or in separating the legs. In well-marked cases the legs are stiffened as the child lies in bed from time to time, especially the feet, which are also turned in (equino-varus). There is contraction of the adductors and extensors of the thighs. At times the rigidity becomes marked; often the knees are held in slight flexion, and it requires some force to move them. On exciting this, the limbs are thrown into a tremor, which may be limited to the feet or may extend to the muscles of the trunk,—in fact, to the whole body. If the child be placed upon its feet by grasping it by the body or arms, the thighs, which are flexed upon the pelvis more or less, will be adducted, the knees touching, the feet will assume a position of forced extension. In attempting to walk, the feet will drag along the ground, stumble over the least obstacle, and constantly interfere with each other. None of the children reported could walk absolutely alone: one could walk a few steps when supported by an object upon which it rested the weight of the body by the arms; the gait was shuffling. The epileptiform tremor of the muscles is at first provoked by standing, and this greatly hinders the walking. In three cases reported, the upper extremities were not involved. This is not absolutely the rule in all cases, but, when the arms are involved, this follows the trouble in the lower limbs, usually at a long interval. In such cases there is a paresis of the muscles without involuntary flexion of the fingers at first, which is intermittent in character and then permanent. The wrist becomes rigid in extension and pronation, so also the elbow, and the arm is hugged to the thorax.

With rigidity comes exaggerated tendon reflex, which according to Charcot precedes contraction, and which persists throughout its course and succeeds it. It is usually very marked in the knees, less so in the feet, and in children is less so than in adults. The symptoms remain confined to the motor tract throughout the disease; the usual symptoms, due to disturbance of sensation, which accompany the different forms of myelitis are absent. There is no rachialgia, no feeling of constriction, no pain; neither are there sensations of cold, nor formications, nor fugitive pains, which, if they existed, would soon be made known by children.

* I would suggest a better name in "Symptomatic Spastic Muscular Contracture."

Cutaneous and deep sensibility are normal; there is neither hyperæsthesia nor anæsthesia. In one of the cases observed there was some well-marked anæsthesia of the lower extremities, but the case was a doubtful one. Sometimes, according to Westphal and Berger, interstitial myelitis may extend itself, involving the posterior tract, and then the symptoms of ataxia complicate the spasmodic contraction. The functions of the sphincters are normal; there is neither retention of urine nor incontinence, which is remarkable for children with disease of the cord.

The muscles of the thigh are not atrophied, and electro-contractility is normal. In one of the cases reported nutrition was excellent, in the other two it was somewhat below par, but this was accounted for by the prolonged enforced rest in bed. The duration of the disease is not limited; complete cure is rare. The symptoms persist indefinitely, despite treatment, without much improvement: if they do become aggravated, the disease is even of itself directly fatal. In children the zymotic diseases, and most frequently tubercular disease, make a fatal termination. It is to be regarded as an infirmity rather than a disease, as it will not of itself prevent the patient reaching adult life. We have written of the affection only in its bearing upon children. In adults it is most common at the age between thirty and fifty, and slightly more frequent in males than in females. The cause is unknown; possibly prolonged exposure to damp cold is the most frequent; in children possibly blows, a fall, or exposure. There is a congenital form, which possibly results from an arrest of or from irregular development in the motor tract, or is traumatic from instrumental or difficult labor. Little records a case such as this, and attributes it to spinal congestion due to asphyxia. Possibly inheritance has its influence. In the case narrated below, the other twin was born with arrested cranial development and lived but a few moments.

The following case serves as an example:

Louis, aged 5 years, entered the hospital (Trousseau) August 30, 1883. The child is a twin; its brother survived but a few moments. The father and mother are in good health; they are not affected with syphilis nor alcoholism. The mother has never miscarried. The child has never walked alone, but since three years old he could stand alone with the aid of a fixed support, and could take a few steps in that way. He began to talk at the age of eighteen months. The disease dates from his eighth month, at which time the mother noticed that she had difficulty in separating the legs of the child; they were straightened and stiffened at times, then became relaxed, and the conditions would again recur, either spontaneously or upon the slightest contact. The arms were in every way normal. About a month after, tremor was noticed when the child was lifted by the arms and held upright on the table. In the following month the contractions increased, and if forcibly overcome would return by themselves at once. Cold douches and faradization brought about some improvement; the permanent crossing of the limbs disappeared, and the intervals existing between the spasmodic contraction of the muscles lengthened.

The condition of the patient at present is as follows. The muscles of the lower extremities are in a state of contraction, the feet extended in equino-varus, and cannot be overcome without considerable force. There is no notable muscular atrophy. When the child is held upright the contraction increases, the inferior extremities are adducted, the feet in equino-varus resting on their metatarsal phalanges. The legs cross, and the foot in advance tends to place itself directly in front of the one supporting the body. The little patient can only take a few steps by supporting himself on his arms. At times the contraction subsides entirely and the limbs become flaccid, but if the limbs are touched, however lightly, or he makes the attempt at movement, the contraction returns. Patellar and plantar reflexes are exaggerated. Faradic contractility is normal. When supported erect, the two limbs take upon themselves epileptiform movements, which can be equally well provoked by seizing roughly the foot in advance. This tremor is more pronounced in the right limb. There has been no pain, either spontaneous or upon pressure. Sensation is normal. The intelligence is somewhat undeveloped. The expression is heavy. Speech normal. The cranium shows faulty development; it is not symmetrical; posteriorly it is flattened. The frontal fossæ, especially the left one, are very prominent. The right occipito-parietal region comes out in bold relief, and the left is correspondingly depressed.

The following typical case, reported by Dr. C. K. Mills in the *New York Medical Record*, September 6, 1879, presented in detail the marked features of the disease, and as I now have the patient under my care, and have been able to study his present condition in contrast to what it was in 1879, I can dwell more at length upon the prognosis.

B. D., æt. 4. Nothing known of the previous history. He has a fair-sized head, but it is flattened a little more than usual from the vertex forward. The fontanels are closed, but the lines of the sutures are projecting and rough. Both pupils are dilated, and according to the nurse they are always in that state. He has left internal strabismus. He has no facial paralysis; he can protrude the tongue without difficulty, and he talks pretty well. He seems to have fair intelligence, but he cries upon the least provocation. His back seems weak, and tends to project backwards as he sits in the chair. He has no spinal curvature. He has good use of his arms, but they show a tendency to flex at the elbows. They frequently get into a semi-flexed position when he is quiet, and sometimes resist extension slightly, but they are not rigid, and he can straighten them himself without special effort. He is unable to stand alone, and if attempts to force him are made he becomes much alarmed; if not held, he falls at once to the floor. Supported by the hand or from behind, he stands in a peculiar position. The legs from the knees upward are slightly drawn together, below the knees they are a little apart. His heels are kept slightly elevated. The thighs are bent on the pelvis at an angle of about 120°, and the legs have about the same inclination as the thighs. The feet turn slightly inward. The flexors and adductors of the thighs and the muscles of the calves feel hard and are in a condition of tonic spasm. He walks in a curious fashion, keeping hold of the hand of the nurse. His legs remain semi-flexed at the knees. He steps on the front part of his feet and toes, the heels never touching the floor. The thigh- and leg-muscles are fully developed, particularly the flexor group. Electro-contractility is generally well retained. Sensibility is good. The limbs are not cold nor changed in color. The joints are free from adhesions. The prepuce is not adherent, and can easily be retracted. When sitting or lying down, his legs can be straightened by the exercise of some force, but they immediately tend to return to their state of abnormal flexion and adduction. Slightly tapping each patella-tendon, the corresponding foot and leg are projected quickly and somewhat forcibly forward. I can produce the same phenomenon by tapping upon the lower part of the tibia. Abruptly forcing the foot into flexion and smartly striking the tendo Achillis, no tremor or oscillation is set up, but the spasm of the flexors and adductors is increased.

Dr. Mills concludes that the disease is one of the motor disorders of the cord of the lateral or antero-lateral columns, but should not be confounded with primary lateral sclerosis, also congenital.

Samuel Gee ("Billroth Hospital Reports," vol. xiii., 1877) writes of spastic paraplegia, and considers the disease as congenital or beginning in infancy. Dr. S. W. Mitchell is quoted by Dr. Mills as having spoken of cases of children with rigidity of the legs from defective cerebral development, and also of cases of spasms of the adductors of the thighs, in which he has had circumcision performed without benefit. Dr. Mills, in this lecture, quotes a case which he saw with Dr. Roland G. Curtin, of this city, where all the symptoms above recorded followed an attack of rheumatism complicated with endocarditis in a girl of 13. She had, in addition, severe pains or aching in the joints or limbs. Under nitrate of silver she rapidly improved, and in two weeks was well.

In the continuation of his interesting article, Dr. d'Heilly (*Revue des Maladies de l'Enfance*, January, 1885) discusses the question as to the cause and seat of this interesting symptom, quoting the researches of Richter and Berger in Germany as showing its dependence in many cases upon a primary sclerosis of the lateral columns. But, again, distinct cerebral symptoms, such as convulsions, in infancy have initiated the attack and the spastic paraplegia following, being in such cases a secondary phenomenon; and in connection with this he quotes Ross (*Spas. Paral. of Infancy, Brain*, October, 1882) as asserting that, although there may be a localized spinal lesion primary, the most usual condition is one of arrest of cerebral development, associated with a bilateral hemiplegia from congenital absence of certain centres; but should this latter explanation be correct, less marked cerebral symptoms should exist than are presented by the cases. Almost all the affections of the cord resulting from pressure or from sclerosis present more or less certain features which show an involvement of the lateral columns; in most of them there is pain or anæsthesia, vesical paralysis or paresis, muscular atrophy or inco-ordination of movement, and the tendency of most of them is to extension.

The ataxia of Friedrich presents many symptoms in accord with this disease. Sensation is normal. The bladder is unaffected, and there is no muscular atrophy. There is muscular inco-ordination and gradual involvement of the arms, and finally speech is affected. Frequent errors

are made in diagnosis in such cases. Even Charcot is reported by d'Heilly as recording a case of supposed spastic paralysis in which the existence of cerebro-spinal sclerosis "en plaques" was found post mortem.

As d'Heilly distinctly emphasizes the fact that "spasmodic tabes dorsalis" never presents any cerebral symptoms, those cases which are recognized as distinctly hemiplegic in character should be eliminated (see excellent paper by Dr. Sarah J. McNutt, *Archives of Pediatrics*, January, 1885), and also double infantile spastic hemiplegia (same author, *Am. Jour. Med. Sci.*, January, 1885). In the latter affection, which more than any other may possibly be confounded with the one in question, Dr. McNutt's exceedingly valuable paper gives us as symptoms "more or less complete hemiplegic motor inability, with contraction and defective development of both bones and muscles," "with or without aphasia, monosyllabic utterances, dysphagia, dyspnœa, and idiocy, the latter being especially characteristic of the double affection."

We have endeavored to epitomize this interesting communication, because we believe these cases to be overlooked in this country or misunderstood. The diagnosis is readily made in marked cases, especially in adults. Doubtless some will read this article and remember cases of their own which had puzzled them. Certainly in the cases referred to by Dr. d'Heilly there was a lesion of a more or less persistent character; but are there not functional derangements, prototypes of the more serious disease, whether disturbances in nutrition or in circulation, which can be influenced by treatment? Can we not have one form depending upon imperfect development of cerebral centres, and another, possibly a difference in degree only, affecting in the same way those of the cord? Cases of functional paraparesis in infancy, with spasmodic adduction, are certainly noted by all who see much of children's practice, and in such cases the muscular wasting, when it does occur, is secondary, owing to want of use.* In our own experience these congenital cases seem to be due to imperfect development, as the intellect shares this condition, though to such a slight extent as only to be noticeable by comparison: the child is said to be backward.

Functional contractions are not infrequent after acute diseases in infancy. A child of my own, at the age of 20 months, had spasmodic closure of the fingers and great rigidity of the wrists immediately following a mild attack of rötheln, which lasted several days (three or four). There was no pain, apparently, and none of the other muscles were affected. When playing, she lifted her toys with the back of her wrists. Nutrition was perfect, the functions normal. In this case relaxation would come on at times, but the slightest touch or effort on her own part would bring about violent contractions. There was relaxation during sleep. I noted this same condition following measles, in an infant, which involved the muscles of both arms and legs, the extensors of the legs and the flexors of the arms, with contraction of the toes and fingers. There was pneumonia in this case, and the temperature ran high. The little patient gradually improved; in fact, in both these cases the improvement was very gradual. Large doses of bromide of potassium, hot baths and friction, with tonics, were used in the first case, and in the latter quinine and poultices in addition. Possibly these cases may be called hysterical. The lesion is evidently an irritative one, but exactly why it should be limited to certain cord-centres and be painless is an interesting problem.

But in such cases as reported by Dr. d'Heilly, when changes have probably taken place of a definite character, and especially if they occur in children but a few months old, our only chance for treatment points to alteratives, tonics, and encouraging nutrition.

Like all other symptoms, contraction may represent in infancy and childhood, as well as in adults, simple irritation (hysterical, possibly), and every grade to advanced disease. I think chorea may be classed in this category also.

As for the treatment of well-marked cases of spasmodic contraction, there seems but little hope of doing good. The disease, whatever its lesion may be, is limited, is never fatal, and after reaching a stage about as advanced as the boy B. D., quoted from Dr. Mills's report, somewhat improves. This boy can now

* This I believe should not be confounded with the so-called idiopathic contracture of infancy, which is the result of irritation and is painful and acute in character.

take a few steps by himself before the muscular spasm upsets him; he is in excellent health, well nourished, muscles firm, and never complains. But in this case the lesion certainly seems to be a bilateral central one. If we are able to recognize the features of the disease of the spinal types in its incipiency, I believe much could be accomplished; and it is for this reason that I bring this matter before you this evening.

All causes of irritation should be removed. If they are males, possibly preputial adhesions are present: they should be broken up or circumcision performed. In my opinion the latter is a most important operation, not so much from the relief to the phimosis, which could be, in many cases, equally well accomplished by stretching (Willard), but owing to the direct results upon the nutrition of the spinal centres, which section of the peripheral terminations of the nerves in the prepuce may bring about, acting as will the actual cautery or blisters in other neuroses. In females I would give warm baths, alternating with cold sponging, especially to the spine, and full doses of bromide of potassium. In incipient cases the bromides are of great importance, with stimulating frictions to the spine, using either mustard poultices, or liniments of oil of amber or croton oil, or possibly dry-cupping. Fresh air and proper diet are, of course, understood; in the latter, milk should always form the principal part, and eggs also, in preference to animal-broths. As regards medication, I would insist upon an emulsion of cod-liver oil, either with liq. acid. phos. comp. (Pepper), or lacto-phosphate of lime. Arsenic is certainly of great value in these cases. As to quinia and strychnia, I feel doubtful as to their use, even in very small so-called tonic doses; for although the condition is possibly an evidence of anæmia, as are chorea and some mild forms of epilepsy, I would prefer to rely on food, iron, arsenic, and fresh air.

In more pronounced cases, when we have decided evidences of "spasmodic tabes dorsalis," and treatment has been of little avail, we might use the bichloride of mercury, in small and frequent doses ($\frac{1}{150}$ of a grain), three times daily; or, if we suspect sclerosis, the chloride of gold and sodium. But I think that the best results are obtained with the nitrate of silver; in it I would place most reliance. Erb is reported as having cured a case with the continued current. Charcot failed with electricity, hydropathy, and cauterization.

HYDROCHLORATE OF COCAINE IN PURPURA HÆMORRHAGICA.

BY WILLIAM F. WAUGH, A.M., M.D.,
Professor of the Practice of Medicine, etc., Medico-Chirurgical College.

A LADY aged 27 years had had several profuse hemorrhages within a period of four months. Her color was still good; her health apparently unimpaired; but her blood had become deficient in coagulability, so that a slight prick on the finger occasioned hemorrhage which was only checked with difficulty.

She had no previous history of unusual hemorrhages. Her mother was subject to epistaxis which on more than one occasion necessitated the attendance of a physician, and at one time continued nearly a week.

Since the middle of December the lady had several premonitory symptoms. On the 18th of December, after unusual fatigue, she fainted. After this date several uterine hemorrhages occurred of small amount. On the 1st of January she complained of a sense of fulness in the head, as if her nose were about to bleed. That evening she took six grains of quinine. Later the same evening she felt something like a fragment of food between two of her teeth, and endeavored to remove it by drawing the edge of a handkerchief between them. At once the gums commenced to bleed from where the handkerchief had been used, and, later, from a number of other places. On the lips, tongue, inside of the cheeks, gums, and roof of the mouth appeared a number of purple spots from the size of a pin-head to that of a silver half-dime. A blue spot the size of a half-dollar appeared on the right thigh, and another on the right shoulder. On the face, neck, chest, and limbs, the spots were smaller and bright red. Slight discharges of blood took place from the womb. The stools were tarry. The face was pale, the skin cool, the pulse weak and compressible. She complained of alternating flushes and chills, and of vertigo whenever she attempted to rise from the recumbent posture. The elbows and knees ached as if they had been bruised.

From this time until the evening of the

3d, I was engaged in trying the various styptics to check the blood which oozed from the gums. Alum, tannin, phénol, phytolacca, and Monsel's solution were used with no appreciable effect. The only local remedy which checked the hemorrhage was ice; and of this the effect was but momentary. Internally, phytolacca, ergot, digitalis, and hydrochloric acid were given. After forty hours the hemorrhage was still increasing.

In this predicament I remembered having read in one of the recent reports upon hydrochlorate of cocaine, that after its use there was less hemorrhage than in operations conducted without it.

I procured a little of a four-per-cent. solution of the drug, and applied it twice to the bleeding gums, and to a spot on the under lip where the blood was just beginning to gush out. The next time I saw my patient, in about three hours, I found the hemorrhage had entirely ceased, except at one point. Here the gum was covered with a clot of blood. I removed this and applied the cocaine solution directly to the bleeding surface, and in five minutes the hemorrhage ceased, and did not return.

On January 5, I removed an eye-tooth, with a very long root, from the mouth of a lady in her eightieth year. She dreaded the operation greatly, as she had had serious hemorrhage from the same cause not long before. When the tooth was extracted the blood began to flow freely; but simply pressing a bit of cotton saturated with cocaine solution into the cavity stopped the hemorrhage at once.

A few days later a lady came to me with a simple inflammatory swelling of the upper lip. I applied the cocaine solution, but in spite of it the inflammation went on to suppuration. This but seldom happens when such cases are treated with continuous applications of hot-water cloths. From these cases I would infer that cocaine has valuable powers in checking capillary hemorrhage of a passive kind, but none whatever in controlling crescent inflammation.

Its physiological action, as determined by applying the solution to the web of a frog's foot, is to cause contraction of the blood-vessels, followed by dilatation. This secondary dilatation, however, did not occur in the case of purpura.

I wish to add one more to the uses of this drug as a local anæsthetic. The removal of hairs from the lips and chins of ladies, by electrolysis, is in some cases exceedingly painful. To many the operation is practically painless. Others bear the pain with patience for the sake of getting rid of the ugly deformity. But to anæmic, highly neuralgic persons the pain is sufficient to deter them from the operation. In several cases of this kind I have found that applications of the four-per-cent. solution to the skin, repeated every ten minutes, render the process absolutely free from pain.

1521 Arch Street, January 20, 1885.

STATISTICS OF NEPHRECTOMY.

BY CHARLES BAUM, M.D.

VERY general interest has recently been aroused by the surgical operations upon the kidney. Among these, incision into a kidney, or *nephrotomy*, can probably claim the greatest antiquity, being mentioned by the early writers on medicine. The removal of a calculus from a kidney by enlarging an existing sinus is also of ancient practice; but the operation of the removal of the renal calculus early in its formation and before the enclosing structures have become implicated was performed first by Henry Morris, of London, at so recent a date as 1880. As "floating kidney" has been observed in quite a number of persons, being more frequent in women, surgeons have attempted to remedy the difficulty permanently by suturing the organ to an incision in the parietes. This procedure, called *nephrorrhaphy*, promises well, the results thus far having been encouraging.

Vivisections have repeatedly and fully shown that animals can live after the extirpation of one kidney, and many examples of congenital absence of a kidney have also been found in the post-mortem room. Having these facts in mind, the late Gustav Simon, of Heidelberg, projected and successfully performed the first *intentional* extirpation of the entire kidney, or *nephrectomy*, operating by the lumbar incision. Since his successful case, many operations have been recorded, one hundred of which have been tabulated by Dr. Robert P. Harris in the *American Journal of the Medical Sciences* for July, 1882. The annexed table comprises seventy-two additional cases:

No.	Reference.	Date of Operation.	Operator.	Sex and Age.	Incision (A. Abdominal; L. Lumbar).	Diseased Condition.	Recovered; Died.	Cause of Death.
1	Western Lancet, 1882, p. 486, and Letter, Dec. 27, 1884....	1869	Lane.....	F., 35.....	A.	Floating kidney.....	D.	Peritonitis.
2	Brit. Med. Jr., 1882, ii. p. 929.	May 8, 1881	Tait.....	F., 24.....	L.	Variety of tumor not stated; three and a half months prior failed by abdominal section, as intestines were too matted.....	R.	
3	Deutsches Med. Wohnsch., Berl., 1882, xiii. p. 702.....	Mar. 20, 1882	Schede.....	F., 26.....	A.	Hydronephrotic sac.....	D.	Collapse.
4	Lancet (Lond.), 1882, ii. 567..	June 20, 1882	Eider.....	F., 36.....	L.	Scrofulous pyelitis; nephrotomy three weeks prior.....	R.	
5	Berlin. Klin. Wohnsch., 1882, xix. p. 745.....	July 1, 1882	Bruntzel.....	F., 33.....	A.	Fibroma of capsule and left kidney removed; weight, 37 pounds; intestine ruptured; exploratory incision.....	R.	
6	Brit. Med. Jr., 1882, ii. p. 100.	July 12, 1882	Heath.....	Child.....	...	Scrofulous kidney.....	D.	
7	Ibid., p. 1299.....	Aug. 10, 1882	Keeling.....	F., 23.....	A.	Cystic kidney; supposed ovarian.....	R.	
8	Liverp. Med.-Chir. Jr., July, 1883, p. 252.....	Sept. 2, 1882	Rawdon.....	F., 16 mos.	A.	Carcinoma with cysts; weight, sixteen and one-half ounces.....	D.	Collapse (carbolic spray as factor).
9	Phila. Medical Times, 1882-3, xiii., p. 67.....	Sept. 16, 1882	Goodell.....	F., 52.....	A.	Hydronephrosis.....	R.	
10	N. Y. Med. Jr., 1883, xxxvii. p. 171.....	Oct. 14, 1882	Wright.....	F., 34.....	A.	Chronic pyelitis and, possibly, calculus; stone weighed 135 grains	R.	
11	W. Lancet, 1882, pp. 433-481..	Oct. 14, 1882	De Vecchi.....	F., 33.....	A.	Pyonephrosis; weight, 11 ounces.....	R.	
12	N. Y. Med. Jr., 1883, xxxvii. p. 171.....	Nov. 2, 1882	Polk.....	F., 19.....	A.	Misplaced left kidney; absence of right kidney and ureter, also uterus and vagina.....	D.	In eleven days and one hour; convulsions and coma.
13	Med.-Chir. Tr., lxvi. p. 305, 1883.....	Dec. 13, 1882	Sir T. S. Wells	M., 38.....	A.	Soft cancer; six and one-half inches long, 4 inches wide.....	D.	Bloody urine; slight peritonitis.
14	Brit. Med. Jr., 1883, i. p. 1004	Dec. 22, 1882	Rawdon.....	M., 12.....	L.	Traumatic rupture of right kidney; lateral cystotomy in four days for cystitis caused by blood-clots.....	D.	Pyelitis and abscess in left kidney; decomposing clots and retention of urine.
15	Dublin Jr. Med. Sc., 1883, 3s., lxxv. p. 86.....	1882	O'Reilly.....	F., 26.....	L.	Primary tubercular kidney.....	D.	Collapse.
16	Lancet (Lond.), 1883, i. p. 423; from Gaz. degli Ospital., Feb. 18, 1883.....	Dec. 20, 1882	D'Antona.....	F., 26.....	L.	Pyonephrosis.....	R.	
17	Ibid	.....	Novaro.....	.....	...	.....	R.	
18	Md. Med. Jr., xi. p. 429; from Wien. Med. Woch., 1884, Nos. 23, 24, 25.....	Jan. 5, 1883	Billroth.....	F., 38.....	A.	Myxo-sarcoma; diagnosis of retro-peritoneal fibroma.....	R.	
19	Tr. Pathol. Soc. Lond., 1883, xxxiv. p. 141.....	Feb. 2, 1883	Thornton.....	F., 53.....	A.	Tumor of capsule; kidney healthy; diagnosed ovarian.....	R.	
20	Lancet (Lond.), 1883, i. pp. 424-548.....	Mar. 3, 1883	West.....	M., 15.....	L.	Traumatic rupture of left kidney; suppuration; nephrotomy, first; weight, 16 ounces.....	R.	
21	Md. Med. Jr., 1884, xi. p. 406	Mar. 3, 1883	Billroth.....	F., 40.....	L.	Urinary fistula after double ovariotomy; fetid pus.....	D.	Exhaustion.
22	Ibid., p. 426.....	1883	Billroth.....	F., 28.....	A.	Supposed stenosis of pylorus; right normal kidney removed.....	D.	Retro peritoneal cellulitis, peritonitis, and pleurisy.
23	Brit. Med. Jr., 1883, i. p. 1226	Apr. 9, 1883	Whitehead.....	F., 45.....	A.	Abscess.....	D.	Shock.
24	Med. News (Phila.), 1883, xlii. p. 547.....	1883	Palmer.....	F., 19.....	A.	Pyonephrosis.....	D.	Peritonitis.
25	Ibid., p. 646.....	Apr. 20, 1883	Gross.....	F., 59.....	A.	Medullary cancer (partial choleocystectomy for calculus also); diagnosis uncertain.....	D.	Peritonitis and suppression of urine.
26	Brit. Med. Jr., 1883, ii. p 615	Apr. 20, 1883	Walter	F., 42.....	A.	Cystic tumor of floating kidney.....	R.	
27	New Eng. Med. Gaz. (Homœopathic), 1884, xix. p. 266 ..	Apr. 27, 1883	Boothby.....	F., 27.....	A.	Painful movable kidney (left)	R.	
28	Lancet (Lond.), 1883, i. pp 963, 1104.....	May 8, 1883	Israel.....	F., 21.....	L.	Pyonephrosis.....	D.	Acute tuberculosis.
29	Bull Acad. de Méd., Par., 1883, 2s., xii. p. 1077.....	June 9, 1883	Ollier.....	F., 22.....	L.	Pyelonephritis; nephrotomy six months prior.....	R.	
30	Ibid.....	1883	Ollier.....	Child, 4.....	A.	Sarcoma.....	D.	Shortly from syncope.
31	Ibid.....	1883	Ollier	F.....	A.	Large cyst.....	D.	
						Scrofulous and cystic kidney.....	D.	Syncope on third day while retching.

32	Lancet (Lond.), 1884, i. p. 13..	June 19, 1883	Jowers.....	F., 55.....	A.	Scrofulous and cystic kidney.....	D.	Syncope on third day while retching.
33	Med. Times and Gaz., 1883, ii. p. 268	July 12, 1883	Kidd.....	F., 28.....	A.	Abscesses.....	D.	Collapse.
34	Med. Record (N. Y.), 1883, xxiv. p. 583.....	Aug. 1883	Wylie.....	F., 34.....	A.	Tuberculous and movable; diagnosed movable kidney.....	D.	
35	Brit Med. Jr., 1883, ii. p. 438	Aug. 11, 1883	May.....	F., 24.....	L.	Scrofulous kidney.....	D.	Suddenly; suppression of urine; other kidney diseased.
36	Lancet (Lond.), 1884, ii.p 778; Brit. Med. Jr., 1884, ii. p. 863	Aug. 1883	Godlee.....	M., 22 mos.	A.	Mixed sarcoma; weight, about 1 pound.....	R.	D ed of return six months later.
37–41	Lancet and Brit. Med. Jr.....	.....	Thornton.....	.....	5 A.	.....	5 R.	
42	Ibid.....	.....	Meredith.....	F., 4.....	A.	Round-celled sarcoma.....	D.	Vena cava inferior ligated; new growth in lungs.
43	Brit. Med. Jr., 1884, i. p. 758.	Nov. 13, 1883	Sir T. S. Wells	F.....	A.	One-third of left kidney removed with two solid circumrenal tumors; fibrolipomata; weight, 16½ and 14½ pounds; not diagnosed.....	R.	
44	Ibid., 1883, ii. p. 1031, and 1884, ii. p. 575.....	Nov. 13, 1883	Davy.....	M., 53.....	L.	Fibro cystic disease; 7 x 2½ inches; preceded by exploratory abdominal incision.....	R	Died two months later from encephaloid cancer of liver, bladder, and left ureter; calculus impacted in new growth.
45	Ibid., 1883, ii. p. 1031.....	Nov. 14, 1883	Thornton.....	F.....	A.	Tubercular disease.....	R.	
46	Bost. M. and S. Jr., 1884, cx. p. 73.....	Nov. 24, 1883	Homans	M., 29.....	A.	Cancer; weight, 3½ pounds.....	D.	Acute general peritonitis.
47	Brit. Med. Jr., 1884, ii. p. 1075	Oct. 24, 1883	Morris.....	M., 35.....	L.	Calculus; kidney harder and firmer than normal.....	R.	
48	Cincinnati Lancet and Clinic, 1883, n. s., ii. p. 571.....	Nov. 2, 1883	Dandridge.....	F., 22.....	A.	Probably strumous disease; thick, fatty contents.....	D.	Hemorrhage.
49	Brit. Med. Jr., 1884, ii. p. 123	Dec. 24, 1883	MacEwen.....	M., 11.....	L.	Calculus.....	R.	
50	Tr. Med.-Chir. Soc. Edin., iii., n. s., p. 35; Edin. Med. Jr., 1884, xxix. pt. 2, p. 896	1883	Duncan.....	F., 21.....	A	Pyonephrosis.....	D.	Abscess in stump of ureter opened into bowel; exhaustion.
51	Brit. Med. Jr., 1884, ii. p. 424	1883	Kosinski.....	.....	A.	Enlarged lipomatous kidney containing nine calculi.....	R.	
52	Ibid., 1884, i. p. 453.....	1884	Savage.....	.....	A.	Pyonephrosis.....	D.	
53	Ibid., p. 1262.....	1884	Boeckel.....	F., 40.....	A.	Urinary fistula after hysterectomy; died in seven months, of cancer of abdominal glands and parenchymatous nephritis.....	R.	
54	Md. Med. Jr., xi. p. 429; from Wien. Med. Woch., 1884, Nos. 23, 24, 25.....	Feb. 16, 1884	Billroth.....	M., 33.....	L.	Probably interstitial papilloma.....	R.	
55	Brit. Med. Jr., 1884, i. p. 1261	June 21, 1884	Bantock.....	F., 33.....	A.	Tuberculous kidney.....	...	
56	Med. and Surg. Reporter, li. p. 700.....	Oct. 26, 1884	McLean.....	F.....	A.	Pregnancy suspected; large cystic kidney, both ovaries, and part of great omentum removed.....	...	
57	Med. News (Phila.), 1884, xlv. p. 707; N. Y. Med. Jr., Dec. 27, 1884.....	Nov. 3, 1884	Weir.....	F., 23.....	L.	Pyonephrosis.....	D.	Venous hemorrhage, shock.
58	Ibid. and letter.....	.....	Halsted.....	.....	A.	Carcinoma.....	D.	
59	Ibid.....	.....	Thomas.....	.....	A.	Fibroma.....	D.	Shock.
60	Ibid.....	.....	Thomas.....	.....	A.	Carcinoma.....	D.	Shock.
61	Ibid.....	.....	Lange.....	.....	L.	Suppuration after nephrotomy.....	D.	
62	Ibid.....	Feb. 16, 1884	L. A. Stimson..	.....	A.	Painful movable kidney.....	D.	Peritonitis.
63	Gross's list.....	.....	Archer.....	F.....	...	Wound in ovariotomy.....	R.	
64	N. Y. Med. Rec., 1882, ii. p. 302 (reprint).....	1882	Cullingworth....	.....	A.	Hydronephrosis.....	D.	Shock in two hours.
65	N. Y. Med. Jr., Dec. 27, 1884	.....	Little.....	Child, 4.....	...	Sarcoma.....	D.	
66	Schmidt's Jahrb., Bd. cci., n. s., 28., p. 165.....	.....	Bergmann.....	.....	...	.....	D.	
67	Ibid.....	.....	Bergmann.....	.....	...	.....	D.	
68	Arch. Gén. de Méd., Paris, 1884, i. p. 641.....	.....	Le Dentu.....	.....	L.	Urinary fistula after nephrotomy.....	R.	
69	Budapest, 1882, xxiv. 785.....	.....	Reczey.....	.....	A.	Sarcoma...	D.	
70	Lancet (Lond.), 1884, ii. p. 554; from Gaz. degli Ospit., Aug. 31, 1884.....	June 8, 1884	Bottini.....	M., 27.....	L.	Fistula from suppurative calculous pyelitis.....	R.	
71	Ibid., p. 966.....	Aug. 25, 1884	Sonnenburg.....	F., 52.....	...	Calculous pyelitis.....	D.	Collapse and anuria on second day.
72	Ibid., p. 1055; from Il Morgagni for October, 1884.....	Apr. 24, 1884	D'Antona.....	M., 34.....	L.	Calculous pyonephrosis.....	D.	Inanition on tenth day.

Of these 72 cases, 32 recovered, 36 died, and in 2 the result is not stated.

Of 40 females, 17 recovered, 21 died, and 2 not stated. Of 11 males, 7 recovered and 4 died. Of 7 children under 12 years old, 2 recovered and 5 died.

The site for operation was stated in 62 cases, of which 44 were by abdominal section, with 19 recoveries and 25 deaths, and 18 by lumbar incision, with 11 recoveries and 7 deaths.

The conditions demanding the operation were the following: Abscess, 2 died; calculous pyelitis, 2, 1 died; calculous pyonephrosis, 1 died; calculus, 2 cured; carcinoma, 6 died; cystic disease, 4. 1 died and 1 not stated; fibroma, 1 died; fibro-cystic disease, 1 cured; floating kidney, 3, 2 died; hydronephrosis, 3, 2 died; lipoma, 1 died; misplaced kidney, 1 died; misplaced and single kidney, 1 died; myxo-sarcoma, 2 cured; papilloma, 1 cured; pyelonephritis, 1 died; pyonephrosis, 8, 6 died; sarcoma, 4 died; traumatic rupture, 2, 1 died; tubercular disease, 4, 2 died and 1 not stated; tumor of capsule, 2 cured; tumor (?), 1 cured; urinary fistula, 4, 1 died; and wound during ovariotomy, 1 cured.

The chief causes of death were collapse, 5; peritonitis, 4; peritonitis (complicated), 3; shock, 4; exhaustion, 3; hemorrhage, 2; and syncope, 2; while anuria was a factor in 3 cases, and perhaps carbolic-acid poisoning in 1 case.

Actuated by pain, Lane's patient declared she attempted to excise the swelling, and to corroborate the statement directed attention to a cicatrix which was observed upon her abdomen. In attempting to extirpate a renal tumor by abdominal section, Tait failed on account of the great matting of the intestines; nevertheless, the tumor decreased in size and the patient improved. However, as her symptoms reappeared, he removed it three and a half months later by the lumbar incision. Polk removed the misplaced left kidney from a young woman, 19 years old, in whom there was congenital absence of the right kidney and no trace of the corresponding ureter. In this girl the breasts were large, but the labia minora rudimentary, and there was absence of the vagina and uterus, while the ovaries appeared normal, but were misplaced. After the operation frequent emesis and dry skin occurred, but sweating was induced by pilocarpine; finally, after eleven days and one hour of moderate suffering, convulsions and coma produced death.

The kidney which Morris extirpated for calculus was normal in structure, but "harder and firmer" than usual. Two attempts, both digital and with needles, had failed to detect the stone.

The object of this paper has been to present a number of cases of nephrectomy for the study of those who may not have had the opportunity to collect them. For various reasons, it was found impossible to make a complete list, therefore the table does not comprise all the cases operated upon since the paper of Dr. Harris appeared. Much kind assistance has been received from Professors Ashhurst and Gross, of this city, and Professor Weir, of New York.

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REPORT ON THE PROGRESS OF OTOLOGY.

BY CHARLES H. BURNETT, M.D.,
Philadelphia.

(Continued from page 348.)

TREPHINING IN MASTOID AND TYMPANIC DISEASE.

AN article with this title appeared in the October number of the *Dublin Journal of Med. Sciences*, from the pen of W. I. Wheeler, F.R.C.S.I., M.D., and is presented to American readers in the *New York Med. Abstract*, November, 1884. We feel called upon to notice it here, and to criticise unfavorably the views set forth therein.

First, the statement that the membrana flaccida is the most frequent seat of perforation in the membrana tympani is just the reverse of the fact: it is a most unusual seat of perforation, as every otologist knows. It is but fair to state that the author, Dr. Wheeler, does not profess to be an aurist, and hence his inaccuracy on this score is somewhat excusable. Secondly, in the first case, notes of which he gives, in which he trephined the mastoid, there is no good evidence in the history of the case that the perforation was demanded. No pus escaped from the opening for twenty-three hours after the operation. The secretion was undoubtedly then the result of the trepanation. Fortunately, the man recovered, although the dura mater had been exposed by the operation. In

the other two operations there seem to have been symptoms warranting the trephining of the mastoid, but in both of these cases the dura mater was exposed intentionally, as it is stated. Both, however, recovered. This intentional exposure of the dura mater in the operation for trephining the mastoid seems very singular, as aural surgeons endeavor to avoid this complication in operating on the mastoid. And hence we consider the advice and directions given by the author in concluding his article as pre-eminently unworthy of following. In fact, the use of a trephine of the size he seems to have used, judging from the pictures of the button removed from the mastoid cortex, which accompany his article, is to be deprecated. (The diameter seems to have varied from one-half to three-quarters of an inch.) When the mastoid cortex is to be perforated, a small drill or a gouge is used by aurists who have performed this operation the most frequently and the most successfully. After stating where to place this broad trephine, (which is too comprehensive to be safe,) the author concludes his article with these to us seemingly remarkable words: "By adopting this course there will be no danger of wounding the lateral sinus; the tympanum and mastoid cells will be opened, giving full exit for discharge; the *dura mater will be exposed, and should pus exist between it and the cranium there will be ample freedom for its escape.*" (The italics are the reporter's.) This seems to be a strange mixture of general and special surgery, and a very poor exemplification of the latter. To trephine or perforate the mastoid cortex for pus within the mastoid cavity is often demanded, and the indications for it and the method of their fulfilment are now fully established, but a combination of them with laying bare the dura mater is nowhere set forth as desirable. To trephine the skull wall and expose the dura mater has also its indications, but does not enter into mastoid operations as a rule, and hence we have felt that the statements and doctrines contained in the strangely conceived paper under criticism should not go unchallenged by otologists.

PEROXIDE OF HYDROGEN IN MASTOID ABSCESSES.

Dr. A. E. Prince, of Jacksonville, Illinois (*St. Louis Med. and Surg. Journal*, March, 1884), calls attention to the merits of peroxide of hydrogen as a cleansing agent in suppurating cavities.

Peroxide of hydrogen is physically like water, transparent, colorless, limpid, odorless, and tasteless, with sp. gr. 1452, and remains liquid at zero. Chemically, it is one molecule of water connected by a feeble bond to an atom of oxygen, and is obtained by the action of hydrochloric acid on peroxide of barium: $BaO_2 + 2HCl = BaCl_2 + H_2O_2$. Its importance as a therapeutic agent is due to its instability. "In the presence of a variety of substances, as gold, silver, and platinum, fibrin and cellular tissue, it is decomposed into water and oxygen, becoming at the same time a powerful oxidizer."

The fact most interesting to the surgeon is the remarkable power possessed by pus to decompose this agent with liberation of nascent oxygen, which directly adheres to and attacks all the adjacent tissue for which it has an affinity, and it thus becomes a powerful destroyer of bacteria. It is claimed for it that, though inferior to iodoform as an antiseptic, it has the inestimable quality, like it, of producing little or no irritation when used about tender organs. Upon coming into contact with pus in a fetid cavity the liberated gas permeates it, and by the continued evolution of gas the cavity may be emptied of its contents, which boil out at a fistulous opening or any other vent so thoroughly mixed as to appear like froth or foam. Some ascribe to this cleansing character rather than to its antiseptic power its beneficial effects in the treatment of suppurating cavities.

Dr. Prince reports the case of Julia, 8 months old, suffering from suppuration of the middle ear following scarlatina, and after ten weeks supervention of mastoid inflammation and symptoms of general septic poisoning. When examined by him, the child had continued fever and loss of appetite. An examination of the ear revealed destruction of the drum-membrane, exceedingly offensive pus, granulations in the tympanic cavity, with swelling, redness, and heat over the mastoid, or rather over the mastoid region, because a child of this age has no true mastoid cavity any more than it has an osseous auditory canal, as these both have to grow for several years before they can be said to fully exist. A drill was passed through

the outer wall of the mastoid directly into the cavity of the tympanum, and a flexible lead wire passed through from this opening into the tympanic cavity and out through the auditory canal. All injections passed through the drainage-course thus made failed to relieve the patient. Finally a hypodermic syringeful of the peroxide of hydrogen was injected into the drainage-tract from the mastoid opening, the finger being held over the auditory meatus. The liberated oxygen seemed to penetrate the recesses of the mastoid-tympanic cavity, and finally boiled out of the external openings. By repeated injections, so long as any pus remains in a cavity the oxygen will continue to be liberated. Hence when gas is no longer evolved an evidence exists that the cavity is empty and its surfaces free from pus. The constitutional symptoms in the case alluded to began at once to improve, and the case was rapidly cured by the further use of boric acid insufflations alternated with alcohol instillations.

ON THE NECESSITY OF PROVIDING FOR THE BETTER EDUCATION OF CHILDREN WITH DEFECTIVE HEARING IN THE PUBLIC SCHOOLS.

Dr. Samuel Sexton, of New York, has written a paper with the above title (*New York Med. Record*, December 20, 1884), its object being to enlist an interest in the public school system in so far as concerns the needs of the pupils whose disabilities of hearing prevent them from advancing with scholars with good hearing, since it is believed by the author, in common with many others, "that this matter does not receive the attention which its importance demands."

The varieties of deaf children who are believed to be greatly neglected in regard to their education are the following: 1. Children with defective hearing in one or both ears and requiring close proximity and distinct utterance when taught. Of these deafness in both ears requires seating on a front row of benches, but where only one ear is affected the normal ear must be towards the teacher's desk. 2. Children very deaf, who cannot distinguish ordinary conversation in either ear when more than a few inches from the speaker, or unless the conversation-tube or acoustic fan or other aid to hearing be employed. 3. The totally deaf, in whom the auditory apparatus of the middle ear cannot be made available. This class admits of division into two subdivisions,—viz., (*a*) those having learned to talk previous to losing their hearing, and (*b*) those born too deaf to ever have naturally acquired speech, commonly known as congenital deaf-mutes.

Deafness in the schools is then considered from a physician's point of view, as it is believed that the extent and importance of the subject may be more fully realized in this way than in any other, "since where professional advice is required, opportunity is allowed for thorough examination of the hearing organs, both as regards their physical condition and acoustic functions."

Dr. Sexton's experience has led him to the conclusion that "among school-children of the poorer class great injustice is being done in permitting children to struggle for an education under the disadvantages arising from deafness without the aid of methods which experience has shown to be advantageous in such cases."

In New York City it has been shown that some children continue on at school for years while scarcely able to hear, while there are many others who hear very badly. In disregarding this matter deaf children are placed at a serious disadvantage, and time is wasted in futile attempts at instructing them, which proves a hinderance to others who can hear. Great injustice may be done to children with defective hearing, even when they have made great efforts both at school and at home to prepare themselves for promotion, if they are put back at examination, as has resulted because the principal, being unaware of the child's aural defects, has not given his questions distinctly enough for the child to hear them. Deaf children, from neglect to classify them, may be seated too far away from the teacher's desk to hear his voice, and in consequence of inability to hear are often punished for inattention and dulness. In consequence of this misunderstanding many pupils leave the school and lose advantages they cannot afford to dispense with. It is not recommended that the partially deaf should be entirely separated from the hearing pupils, yet it is advisable that pupils should be examined in regard to their hearing, and "that those found to be defective should be given every possible advantage, both in respect to seating and to distinctness of voice in teaching." The very deaf should have some instruction apart from others,

since they cannot hear in some instances words shouted into their ears. An examination of the hearing of five hundred and seventy-five school-children made in 1881 by Dr. Sexton showed that fully thirteen per cent. of the whole number had greater or less hardness of hearing in one or both ears, and that only three per cent. of them were themselves aware of the defect, and only one was thus known to the teachers.

Careful estimates have been made, showing that no more than five per cent. of the entire population of the United States have normal hearing, "but this of course does not show the number of persons defective enough to exclude them from the benefits of the ordinary common-school curriculum. The tenth census computes that there are about thirty-five thousand deaf-mutes in the United States, or one in every fifteen hundred. One-half of these are illiterate." Dr. Sexton carefully estimates the number of totally deaf children unprovided with school advantages in New York City at five hundred. He further makes the important deduction for New York City that, "out of about one hundred and forty thousand pupils in attendance at the public schools at the present time, some fourteen thousand of them would be the better for classification in respect to seating and instruction at short range, or by means of some aid to hearing, and he claims that this avenue to illiteracy — viz., defective hearing — demands attention in a large population where vagrancy and kindred evils are attracting so much attention from the vastness of their proportions.

The author then draws attention to the fact that a very considerable number of deaf-mutes may be more advantageously provided for in the public day-schools than otherwise, as in many cases parents do not like to relinquish their children for purposes of educating them in boarding-schools for the deaf-mute, as they must do if they are to be sent to such institutions as at present organized, with but few exceptions. Day-schools for deaf-mutes have been increasing in number since 1869, with the foundation of the Horace Mann Day-School in Boston. The Oral Branch of the Pennsylvania Institution, a day-school for the very deaf and deaf-mutes, was established in 1881, and the newest ones are the Scranton Oral School, 1883, and A. Graham Bell's School, Washington, D.C., 1883. In such schools as these very considerable numbers who are at present being educated as deaf-mutes could be cared for along with the very deaf who are at present unprovided for, since they both require similar methods of treatment. Furthermore, the education of totally deaf and very deaf children should be undertaken at the age of five or six years, much earlier than is feasible or is done in Deaf and Dumb Institutions. Children who have lost their hearing soon after learning to talk forget this acquisition unless kept in practice. Early education in oral schools for the deaf would enable them to retain speech, and if the congenital deaf-mute is placed in the same school at the same early age, it is not obliged to lose valuable time at an impressible age, as it does if it waits to be admitted to ordinary schools for deaf-mutes requiring a greater age for admission. Children of such tender age must be accommodated with day-schools near home, an entirely practicable matter not only in cities and towns, but in sparsely-settled districts. Other points connected with this important topic will be considered in the next Report on Otology.

"LAWN TENNIS" BACK.

BY CHARLES McINTIRE, JR., M D., F.A.A.M.,

Medical Director, Gymnasium, Lafayette College.

SO much is written about the "tennis arm" and "tennis leg" that I may be pardoned for coining the caption to this article, although the application of the term is not strictly accurate.

While making the preliminary physical examination and measurements of the class of '88, Lafayette, last fall, I found one of the students showing such a marked difference in the development of the muscles of the right side, more especially those of the back, that I was led to inquire his favorite pastime, and found that he was passionately fond of lawn-tennis, so much so that the previous summer had almost been entirely devoted to that sport.

The accompanying photograph* shows much more clearly the marked development on the right side and the want of it on the left than any description, while the

* In the photograph accompanying the communication this want of symmetry is very evident.—ED. P. M. T.

measurements of the upper extremities also show the same disproportion. He is 17½ years old, is 1716 millimetres tall, and weighs 50.25 kilogrammes. The upper-extremity measurements are as follows, in millimetres:

	Right.	Left.
Shoulder . . .	399	373
Arm, biceps contracted	253	232
" " at rest .	230	210
Forearm, muscles at rest	235	209

The lesson to be learned from the case is an easy one. In our anxiety to provide exercise for the young, we must not forget that physical development, while depending upon exercise, is not synonymous with it, and if the exercise is carried on by one set of muscles chiefly, while we may obtain the desired benefits to the circulatory, digestive, and nervous systems, we will also obtain an asymmetrical body. Of course a single case does not afford any foundation for an argument *pro* or *con* as to the fitness of any game as an exercise, and doubtless the many are greatly benefited by the use of the racket; but a caution as to the excessive use of the one arm and an exhortation to become ambidextrous would be a fairly-deduced sermon from such a text.

In this individual case special exercise has been given in the gymnasium, having for its object the development of the muscles of the left side, and we hope before he is graduated to have him symmetrically and well developed.

The need of giving more thought to the matter of physical development by the physician, as the health-conservator of the nation, is emphasized by the examinations now commonly made in gymnasiums. A little observation and a few words of kindly advice would frequently prevent the formation of an irregular development which in after-life is difficult, if not almost impossible, to correct.

CONGENITAL MALFORMATION OF LARGE INTESTINE.—The *Lancet* for January 31 contains a clinical report of the case of a child, two days old, operated upon at the Sheffield General Infirmary by Mr. Atkin, for imperforate anus. The operation of Littré was performed, but the large intestine could not be found. At the autopsy it was found that the whole colon and rectum were rudimentary and apparently solid, although a little meconium could be pressed through it by exercising considerable force. The anus was imperforate.

NOTES OF HOSPITAL PRACTICE.

UNIVERSITY HOSPITAL.

CLINIC OF JOHN ASHHURST, JR., M.D.,

Professor of Clinical Surgery in the University of Pennsylvania.

Reported by LOUIS J. LAUTENBACH, M.D.

DRY SYNOVITIS, WITH INTRA-ARTICULAR ADHESIONS OF SHOULDER-JOINT.

THE first patient whom I have to show you to-day is a little girl who has received a slight injury of the right shoulder, which has been followed by pain and some limitation of the motions of the limb. Taking the arm in my hand, I find a decided crackling on movement. This is what is known as false crepitus: it is a dry crackling, which is rather felt than heard, and which is produced by the rubbing together of roughened surfaces which are ordinarily smooth. It may be intra-articular, from the friction of the head of the bone in the glenoid cavity, or it may be developed in bursæ, or in the synovial sheaths of tendons. It may occur with arthritis, and also with periarthritis. It may be connected, that is, not only with disease of the joint, but also with disease of the tissues around the joint. Between these two sources of origin it is often very difficult to make the diagnosis, and it is frequently only by the most careful examination that the intra-articular or extra-articular nature of the disease can be determined.

My first impression on looking at this patient was that the stiffness and crackling on motion were periarthritic, but more careful examination while the child is etherized shows that the tissues surrounding the joint are soft and healthy. The disease is not arthritis, but a synovial affection which is described by Mr. Barwell as dry synovitis. There is a change in the synovial surfaces of the joint, causing a dry crackling when the parts are rubbed together.

Periarthritis is a condition of considerable importance as being frequently met with and often not recognized. It has been particularly studied by French surgeons, especially by Gosselin and Duplay, who have furnished excellent accounts of the affection as observed in the tissues around the shoulder and the knee. One lesion, which is sometimes met with in this disease as located in the shoulder, has been

described for many years and has been misunderstood. I refer to the lesion described as dislocation of the tendon of the long head of the biceps muscle. There is reason to believe that in most, if not in all, of the cases in which the tendon has been found displaced from its groove, this condition has been not the result of injury, but of chronic inflammatory changes due either to rheumatoid arthritis, or, which I think is more often the case, to the extra-articular affection which we know as periarthritis.

Here there are no evidences of a change outside of the joint. I think that this is a case of dry synovitis, with a certain amount of intra-articular adhesion. I intend to move the arm forcibly so as to break up the adhesions, and then to apply equal parts of mercurial and belladonna ointment, and fix the limb for forty-eight hours to prevent any inflammatory reaction. At the end of that time the movements may be repeated, and, if the child's parents can be induced to co-operate with the surgeon in maintaining mobility, complete restoration of function may be expected. The results of treatment in these cases, however, depend almost entirely upon the care which is exercised by the parents or friends of the patient.

In trying to break up adhesions in the shoulder-joint you must fix the scapula, as otherwise it will move with the arm; then with a series of short but rapid jerks (for you want to break and not to stretch the adhesions) you should move the limb in various directions, first by flexion, then by extension, and finally by rotation and circumduction. Doing this while my assistant fixes the scapula, I can feel the adhesions giving way. By what may be called gentle violence you can thus accomplish your purpose; but of course you must not use too strenuous efforts, as by so doing you might break the bone or perhaps lacerate the great vessels or nerves in the axilla. These manipulations may be repeated after forty-eight hours, provided that the joint does not feel hotter than the surrounding parts; but if its temperature is still elevated at the end of that time, the interval must be made longer.

CASE OF SYPHILITIC OSTEITIS AND NECROSIS OF ULNA.

This young woman, with a syphilitic gumma upon her forearm, has also some sinuses around the elbow-joint evidently leading to disease of the olecranon.

Here we have dead bone present, and the process of separation is so slow in syphilitic necrosis that we are justified in interfering when we would not be so in a case of ordinary necrosis. The rule in ordinary cases of necrosis is not to operate until the dead bone has become loose, but frank sequestra do not form in syphilitic necrosis. I will make an incision down to the bone, and will endeavor to scrape away the diseased surface.

I do not expect to find here any well-marked line of demarcation between the living and dead bone. If I were to remove all the bone which did not appear entirely healthy, I might perforate the olecranon and thus open the joint, a complication which, although not very dangerous, yet should be avoided if possible.

I make a longitudinal incision, push back the tissues, and endeavor to remove the diseased bone without going further than is necessary. I must not get too near the tip of the olecranon, as I do not wish to interfere with the attachment of the triceps muscle. With the thumb-gouge I can scrape away the dead bone. Probably the surface only is necrosed, and I can thus get a sufficiently healthy layer of bone to allow granulations to form and the parts to heal. There are no sequestra here to come out. The operation is rather like one for caries.

We will over the wound use the ordinary dressing of oiled lint, oiled silk, and bandage. On the gummatous tumor we will use mercury and belladonna ointment, and will get by this means both the anodyne effect of the belladonna and the absorbent effect of the mercury. We will put the patient under the use of iodide potassium continued for a long while. Under this treatment she will no doubt improve, and probably the ulceration will heal. I must say, however, that operations for syphilitic necrosis are not very satisfactory, and that we may not succeed in obtaining a cure without further interference.

APOMORPHINE IN ASTHMA.—Dr. Weber, of Darmstadt, has used apomorphine, in doses of one-twelfth of a grain three times a day, in chronic asthma, with success. One patient was entirely relieved who had been a sufferer for thirty years.—*Chicago Medical Journal.*

TRANSLATIONS.

CARBOLIC-ACID INHALATIONS IN THE TREATMENT OF DIPHTHERIA.—Dr. Ludwig Stumpf, of Munich, contributes a very valuable paper on the treatment of diphtheria to the December (1884) number of the *Deutsches Archiv für Klinische Medicin.* He concludes that the diphtheria of the throat, nose, vagina, and mucous membrane of all the air-passages is in the first place a local disease. Commencing as a purely local affection, it will progressively develop into a general systemic infection of the whole body. From the local nature of the infection, topical treatment of the disease is justifiable and in accordance with the opinions commonly held at present. If a local disinfection is accomplished soon enough in accordance with the Listerian principle, all can be accomplished which is needed. The best treatment is the inhalation-treatment. Up to the present time we have no remedy against the general systemic affection. The object of the physician should be to grasp the local primary disorder as speedily as possible, before the general system has been invaded. The importance of this primary treatment, therefore, cannot be overestimated. By neglecting the proper local treatment the general infection of the body will result, and when this takes place our medical efforts are often unavailing. Such cases are generally fatal.

The value of a remedy in the treatment of diphtheria is to be estimated by its disinfecting properties, or, in other words, its bactericide action. The best means of combating the disease is the application of medicated vapor by inhalation, selecting those remedies which possess the greatest antiseptic properties with the least injury to the patient. Helfer was the first to use the atomized solution of carbolic acid in proportions of 1 : 50 and 1 : 30, and has published his excellent results in the treatment of sixteen cases by this method. Rauchfuss considers this application too strong; but Stumpf, on the contrary, believes that these remedies have been disappointing to many experimenters because they were too weak! The full antiseptic and parasitic action of the carbolic acid is only developed by a five-per-cent. solution. Stumpf uses a solution of this strength from five to seven minutes by steam atomizer every hour. No disinfecting remedy is so powerful in its operations and at the same time so harmless to the patient as carbolic acid. Its action requires only to be seen to be appreciated, as demonstrated in the prompt cleansing action of the mouth and throat. After a few inhalations of a five-per-cent. solution the disagreeable odor of the breath disappears, and the loosening of the discolored membrane goes on rapidly without any odor. This treatment of the membrane by carbolic acid is painless, and so much the less painless in proportion with the amount of the deposit. If properly managed, the destruction of the healthy mucous membrane by this treatment is not to be apprehended. By the admixture of the steam in this treatment, the five-per-cent. solution is really reduced to three or even two and a half per cent. by the time it reaches the throat. [During its use attention should be given to examination of the urine to detect any evidence of toxic action.] P.

QUININE IN TYPHOID FEVER.—Dr. Goldscheider, in the December (1884) *Deutsches Archiv für Klinische Medicin,* in an article upon the Action of Quinine in Typhoid Fever, says that undoubtedly quinine has an effect upon the "typhus curve" which is usually exhibited after each dose. This effect is neither specific nor absolute, but it requires certain conditions. It is dependent upon the quality of the fever. It does not in general break the typhoid fever, neither does it shorten it, but operates in diminishing the pyrexia. It supports the remitting tendency, and it has a certain influence upon its exacerbation. In consequence of this, like every remedy, it has an uncertainty in its action, because its effect is dependent upon unknown conditions. In severe forms of the disease the therapeutic effect is in most cases unsatisfactory, particularly in the first half of the disease; during the second half it operates better. It is in the latter stage especially that its antipyretic effects are best observed. The general condition and the pulse also will be improved by its employment at this stage of the disease. P.

ECZEMA DUE TO IODOFORM.—In the *Deutsche Med. Wochenschrift* for July 24, 1884, Dr. A. Neisser cites several cases in which iodoform applications caused an obstinate eczematous eruption. Possibly the drug was adulterated.

PHILADELPHIA
MEDICAL TIMES.

PHILADELPHIA, FEBRUARY 21, 1885.

EDITORIAL.

OVERWORK AND NEURASTHENIA.

IN the Toner Lecture delivered last year by Dr. Chas. K. Mills, of this city, the subject of Mental Overwork and Premature Disease among Public and Professional Men was very appropriately selected, at the suggestion of the founder of the lectures, and to its consideration the lecturer brought the results of considerable clinical observation and original investigation. His statistical studies of men in political and official life, and also of professional men considered as a separate class, favor the views already generally held,—that intellectual work does not of itself injure health or shorten life, but mental overwork, particularly when associated with emotional strain, is a frequent cause of nervous break-down and premature disease. He considers that the longevity of men in the higher walks of public life is less in this country, generally speaking, than in England, basing his opinion upon the average age at death of public men. It does not appear, however, that sufficient importance is given to the fact that in Great Britain the responsibilities of political life are, as the rule, begun later, while the time actually devoted to the duties of public life is less and the attendant mental strain much lighter, than here.

The lecturer cites, among the special causes of premature disease in public life, the onerous and perplexing duties required by service on committees, the uncertainties and disappointments of this life, and the strain to which candidates are subjected during political campaigns; with lack of recreation, and the social excesses and abuses at the national capital.

Among physicians, lawyers, and journalists the performance of brain-work under pressure for time, and under bad hygienic conditions, is a common cause of ill health. Defective education and pecuniary embarrassment are also special causes of nervous break-down and premature disease among physicians and lawyers. The mischievous system of severe competitive examinations in vogue in many communities is justly and unsparingly denounced as injurious both to teachers and scholars.

The connection between neurasthenia and lithæmia, which had been noticed by Murchison, Da Costa, and others, is acknowledged, and their frequent concurrence admitted. Dr. Mills considers, however, that they are by no means convertible terms. The connection between mental states and disease of the body is also dwelt upon, and among the diseases most likely to be developed by mental overwork he places phthisis, diabetes, and Bright's disease; finally the conclusion is deliberately expressed that many diseases not nervous in their seat or manifestation are developed directly or indirectly as the result of mental and nervous strain, through exhaustion, impairment, or lesion of the centres of the organic functions; in fact, overtaxing the mind and nervous system may be the exciting cause of almost any serious disorder to which chance, accident, imprudence, or infection exposes the individual.

This most important subject is ably presented by Dr. Mills, and in a manner which suggests an interesting topic for discussion. The pathology may be summed up in the statement that "in cases of mental overwork tissues fail to regenerate as fast as they break down." But may not the assimilative and regenerative powers be greatly reduced by accident or disease? Of course it is admitted that overwork is a purely relative term, and, while one would find his mental powers

severely taxed by a simple arithmetical problem, another will excite astonishment by his extraordinary capacity for mental labor. It would be of great interest and value to inquire into the precise condition of the brain underlying temporary differences of mental power, apart from the influence of education or habit, and aside from the native difference in brain-structure. Admitting the truth of the observation, it would be very profitable to study the exact conditions which make cerebration more facile and efficient at one time than at another.

It is well known that brain-workers sometimes can do a great deal, and at other times, when "not in the humor," they cannot write at all. Now, in what does this humor consist? Has it a physical basis? How is it affected by states of the brain or of the blood-supply? How is it affected by stimulants or by drugs?

Under the conditions of modern civilization, the question how to maintain the brain at its highest point of efficiency compatible with its normal nutrition is one of the most important that could be discussed. We think that its elucidation would powerfully influence public opinion as to the dangers of stimulants and narcotics, and might possibly tend to decrease greatly the consumption of alcohol and tobacco.

A NEW HOSPITAL WANTED.

IF, as the French say, nothing happened except the unforeseen, we should not be called upon to chronicle the disaster of the 12th instant, in which a wing of the Insane Department at Blockley was destroyed by fire and at least twenty of the unhappy inmates were suffered to perish miserably. It does not often happen that a prophecy is so promptly fulfilled as that contained in our last issue, in which the warning was given that the Kankakee horror might be repeated at our very door if prompt action were not taken to guard against it.

The report of Drs. Wood, Mitchell, and Mills, of the consulting medical staff of the Hospital, to the Board of Guardians, pointing out some of the glaring defects in construction and administration in this department, was indeed timely, and they are to be congratulated upon having done their duty. It is true that one of the city fathers has originated the striking idea that the publication of their letter to the Board, showing the unprepared condition of the hospital for just such an accident as occurred, was the indirect cause of it by inciting some weak-minded inmate to set fire to the building. Although this hypothesis, considered as an explanation of the accident, might satisfy the mind of a political partisan, it by no means furnishes a reason for the disgraceful state of affairs that made such an occurrence possible. It should be said, to the credit of the medical attendants and Miss Fisher's trained nurses, that by their exertions the disaster was much less fatal than it might have been.

The fact is that Philadelphia needs a new hospital and a new almshouse. There is no good reason at present for associating these institutions, but, on the contrary, many reasons in favor of keeping them as separate and as distinct as possible.

The present is a good time to move in this matter, while public attention is still directed to it. The various medical societies should as soon as possible adopt resolutions calling attention to the needs of the sick poor, asking that the Philadelphia Hospital be torn down and rebuilt in a style more worthy of the city whose name it bears, and requesting the removal of the insane department and the almshouse to a location some miles away from the heart of the city. The exigency is so imperative as to warrant calling a public mass-meeting to memorialize Councils upon the subject, and in this matter physicians should take an active and prominent part.

NOTES FROM SPECIAL CORRESPONDENTS.

PARIS.

AN attempt will be made at giving a *résumé* of what is going on of practical importance, at present, in the hospital clinics and the colleges of medicine here.

After-Treatment of Breast-Amputations.—The immediate union, or by "first intention," is not admitted to be the best way of attempting to dress these wounds by many of the Paris surgeons. Here, as elsewhere, they are divided into two camps. M. Mouchez has lately given an account of eleven cases of removal of breast tumors. Several of them were very serious cases, but all of them were united at once under the antiseptic system and healed by first intention. M. Mouchez is of the opinion that a return of the tumor is often prevented by immediate union, or at least that a longer delay is procured in this way than by the old system. M. Verneuil, speaking at the Surgical Society, said, "For my part, I am opposed to any attempt at uniting breast-wounds at once. Unless they are slight ones, made for very small benign tumors, the immediate reunion of the parts presents grave dangers, and I am sure that many surgeons will agree with me in this matter. It is always very difficult to unite them, and this very fact is a strong argument against doing so. Many of these operations, properly performed, leave a wound of at least twelve to fifteen centimetres wide, which is almost, if not quite, impossible to join. This being so, those who wish to have an immediate reunion are forced to do what I call very parsimonious operations, and such attempts will do more than anything else to bring about a return of the tumor. I only want the record of my operations at La Pitié Hospital to show you that these wounds are not at all best treated by an attempt at union by first intention. In my last thirty-five operations I had only one death, which was that of a woman who had a cancer that had its seat in a deep organ. In all of these cases I had no erysipelas or any other complication, except in one case, which was that of a young woman upon whom I operated for a small adenoma; and, as the incision was slight, I thought I was justified in closing at once, but with bad effects, for erysipelas came on. I prefer even to exaggerate my tendency to leave these wounds open rather than to attempt to reunite them at once. It may be said that the cure takes a long time. What are the facts? My results are these: When I am forced to clean out the axillary space, it takes two months in all to get a perfect cure; but the most of my patients get up after fifteen days, and at the end of three weeks they return home to finish their cure. Now, what do we see with immediate reunion? It takes them at least three weeks to heal, and when it succeeds it almost always leaves a point open which takes a long time to cure."

M. Desprès followed in the same strain, and stated that it was only a deception of the eye to see these wounds heal up, for most of them left a fistulous opening that was very difficult to heal and predisposed to erysipelas. He said he dressed them open with a little lint and simple cerate.

M. Polaillon said he was a partisan of immediate reunion if the lips of the wound could be made to meet. He uses Lister's dressing.

M. Le Dentu was in favor of a mixed system of reuniting a part of the wound and leaving the rest open.

M. Trélat. "I am not an eclectic, but I have a system in this matter of primitive reunion. I have always practised it and defended it. It is a rule that I do not depart from if I can help it, but the possibility of doing it will vary according to circumstances. Asepsis is indispensable to success, more so than antisepsis, and I hold that reunion by first intention or an attempt at it is dangerous in the hands of those surgeons who have not been well schooled in the delicate manipulations of asepsis and antisepsis.

"With regard to relapse, I do not believe it will be different in one or the other mode of dressing, if the operation has been complete, which it can be in either system. Differing from M. Verneuil, I commenced by treating tumors of the breast by an open dressing, but since the introduction of the antiseptic methods I have reunited the lips of my wounds at once and whenever possible. If Velpeau and Nélaton did not succeed, it was because they did not take the same precaution that we do,—to leave a drainage-tube, that puts all danger aside of closing a wound."

M. Verneuil said, "I affirm again what I said before: that if these tumors are taken out, as they should be, by removing a large band of the skin and the aponeurosis of the pectoralis major, and even a part of that muscle, it will be almost impossible to make an immediate reunion."

M. Champonnière, in advocating closure of the wound, said, "We make very wide cuts and take out as much as do the partisans of the open system, but that does not prevent reunion unless the tumor has passed from the breast and invaded the skin for some distance beyond. For four years I have always made an attempt to reunite, and when I fail I am no worse off than those who prefer the open dressing."

Treatment of Intestinal Occlusion by the Galvanic Current.—Dr. Boudet has just presented to the Academy of Medicine a new apparatus which he claims can be used by any physician, even should he not be accustomed to the use of electrical applications. By its use, out of sixty-one cases it only failed seventeen times. Of these seventeen, eight were

operated upon by good surgeons, with the result that only two survived. This leaves forty-four cases in which this electrical application was successful, or seventy-two per cent. of all the cases,—a very good showing. The only contra-indication is cardiac asthenia. The apparatus is described as follows:

The intestinal rheophore is composed of a large gum sound, which is to be introduced into the rectum as far up as possible. This sound is armed inside with a metallic hood, that does not pass beyond the eye of the sound. The mandrin, or hood, is connected by a wire to one of the poles of the battery, and it and the sound are connected by means of a rubber tube with a small pump full of salt water. The warm salt water is made to pass through the sound, and at the same time it is charged by the metallic mandrin inside the sound, so that the water passes into the intestine, carrying the electricity to all parts of the mucous membrane. By this plan the danger of direct chemical action is averted, as the extremity of the metallic point does not pass beyond the rubber sound, and is thus isolated. The other pole of the battery is a large plate of metal covered with chamois leather, which is to be applied to the dorsal or abdominal region according to the case. The intensity of the current varies from ten to fifty milliampères, and the duration of its application should be from five to twenty minutes.

Doundakine.—M. Bochefontaine, of the Physiological Laboratory at the Hôtel-Dieu Hospital, is one of our most energetic workers. It was he that swallowed a pill composed of cholera microbes during the late epidemic, to prove that they did not cause the disease. He has lately been experimenting on this drug, the Doundakine, or Doundaké. It is furnished by the *Sarcocephalus esculentus*, one of the Rubiaceæ family, and is grown in great profusion along the African coast from Senegambia to Gaboon. It is an astringent and a real febrifuge, claimed to be equal to cinchona bark. No alkaloid has yet been extracted from it.

Kairine and Antipyrine.—A recent article has brought these medicines into prominence, and now there is great inquiry about them: they are both powerfully antipyretic.

When either quinine or cinchonine is heated with caustic potash, it gives off a vapor which when condensed produces an oily alkaline liquid that has been called quinoleine. The Germans have obtained a number of derivatives of this substance; among them are kairine and antipyrine; they are both soluble in water. Kairine is given in doses from 0.30 to 50 centigr. every hour; the antipyrine is employed in solution:

Antipyrine,	25	grammes.
Alcohol at 90°,	50	"
Syrup orange-peel,	200	"
Distilled water,	125	" M.

Dose of the solution, 3 to 7 grammes, taken at one hour's interval, in the afternoon, when the fever comes on.

These doses make the temperature fall from one-half to two degrees centigrade, and it will often fall to the normal, but rises after two hours' time. Antipyrine causes abundant perspiration and a feeling of well-being; there seems to be no accumulation, and the medicine can be continued for weeks at a time (for five weeks it has been given): it is usually very well supported, but sometimes causes vomiting. There is no injurious action on the nervous system. Both of these remedies are employed in all fevers, in tuberculosis, septicæmia, pyæmia, etc.

Antipyrine was discovered by Knorr in Germany, who sold the right to manufacture it to a firm called Meister Bruning & Co. They in turn sold the right for France to a company who were preparing to make it here. According to the French law, however, no medicine can be patented; but still a process of manufacture can be patented, so the company are trying that dodge, with several prominent doctors here against them. It is hoped that it will be declared free here, when all the great houses will make it, and after a more extended trial we can see if it really has the wonderful powers attributed to it.

While on this subject, it may be interesting to give some of the remedies that were presented this year for the cure of diphtheria.

Diphtheria.—Most of your readers are no doubt aware of the great prize called "*Prix de Saint-Paul*" here, which offers twenty-five thousand francs, or about five thousand dollars, for any remedy that will cure this disease. The following are some of the more serious remedies offered this year:

Quinoleine.

Sulphate of quinine in large doses, three to four grammes a day.

Acid salicylic and alum as a gargle.

Heavy petroleum oil.

Combustion of a mixture of turpentine and gas-tar, to be burned in the room.

Salicine.

There were also the usual number of witches' and other crazy people's cures.

Treatment of Sciatica by Refrigeration.—Dr. Debove has been obtaining excellent results by spraying ether all along the course of the nerve.

Tuberculosis.—Prof. Potain employs the following:

Chloride of sodium,	10	grammes.
Bromide of sodium,	5	"
Iodide of potassium,	1	"
Distilled water,	100	" M.

Sig.—A tablespoonful (15 Gr.) every morning in a glass of milk.

Palpitation of the Heart.—Prof. Potain, of Necker Hospital, recently reported a case of a woman 35 years of age, who had entered for violent palpitations of the heart. This

symptom, he said, seemed to him to be hardly ever a sign of real heart-disease, so much so that it had been said that when "a person complained of palpitation, look for the cause almost anywhere but the heart." This is perhaps bad advice, but it must be admitted as incontestably true that a large number of these patients have nothing the matter with the heart. Nervous palpitation comes from a variety of causes. It is enough almost to say that our patient is a weak, nervous woman, to know that she is particularly impressionable to nervous palpitations; but you must not think that it is a malady special to women, because it is frequent in men. It is true that men are less nervous than women, but when a man is nervous it nearly always manifests itself in palpitations of the heart, real or imagined.

"It is a long time since I have stopped counting the number of young men who have been brought to me for heart-disease between the ages of 17 to 20, before they have done their military service, who afterwards made as good soldiers as any. In these cases the palpitations are simply the result of rapid growth, a sort of hypertrophy of adolescence, which a little convallamarine or iodide of potassium will soon set right.

"We also see these palpitations in middle-aged men who are very nervous: we call them hypochondriacs. Anæmia is also a cause. Among the palpitations of this order can be ranged those that are consequent on certain intoxications, as the exaggerated use of tea and coffee,—very common among the spinsters of old England, who indulge in too much tea. Then there is tobacco. No doubt it will be said that plenty of excessive smokers do not have palpitations; but that does not prove that nicotine will not produce them in persons who are predisposed to such a weakness. In some people who badly digest certain kinds of food, it is enough to produce an attack of palpitation of the heart after eating them; others will have it from certain wines or liquors. Hepatic disease will produce it. In phthisis it is not at all rare. It has been said, When a patient comes to you complaining of palpitation, examine his lungs; when he complains of shortness of breath, then examine his heart. This is an exaggeration, without doubt; but you will be surprised to find how much truth there is in it. Women with uterine troubles will often have palpitations.

"All these different causes will have to be thought of; then try repose, and see if the symptoms are simply nervous or not. There is also a good means of diagnosis in digitalis, for its administration will be without any appreciable action if the palpitations are simply nervous; but if they are kept up or exaggerated by any organic lesion, no matter how small, you will see the characteristic effect of digitalis."

"*Bruits Extra-Cardiaques.*"—At a late clinic, Prof. Potain, in referring to these outside cardiac murmurs, spoke as follows: "A large number of observers have remarked these murmurs in persons in whom no lesions of the orifices could be detected, and they have given many reasons for their cause and nature. Laennec gave an opinion that they resulted from a spasm of the cardiac muscular substance. It has been asserted that these same 'bruits' are the result of an irregular vibration of the folds of the valves, but this is an hypothesis that is not founded on fact or sound reasoning. Again, these murmurs have been considered as resulting from a mitral insufficiency that is purely functional; but the authors of this last theory give no reasons for it. Parrot said that they arose from the insufficiency of the right auriculo-ventricular valve. Laennec remarked that on making these patients suspend their respiration the murmur would stop, while real cardiac ones would continue; but this is very uncertain, and in the greater number of patients it will fail.

"I have studied these cases with great care, and think I can say that these murmurs are to be found very often, as a large number are seen yearly in this hospital. They arise from a rapid inspiration of a certain quantity of air in that part of the lung that is situated between the cavity of the thorax and the ventricle. At the moment of the ventricular contraction a sudden separation of the side of the heart and the walls of the thorax takes place, the lung is drawn into the vacant space made, thus increasing its size; the inspired air that follows this increase in volume is the cause of this '*bruit de souffle.*'"

Treatment of Porrigo, or Eczema Capitis.—Dr. Descroizilles, speaking at the Hôpital des Enfants, said, "This scurf or scall, called popularly '*gourmes*' in children, is quite common, and it will be of practical use to you if I give you our mode of treating it, with a few words of advice. The old pathologists did not admit of treating it at all, and they considered that if you removed the scurf and got rid of the crusts you would bring on all kinds of trouble, including most formidable cerebral affections. But we moderns have not adopted these views; perhaps we have put them aside too much, for one often does see some intercurrent malady appear with the disappearance of the scurf. I believe it is reasonable to take into account the common belief that there is danger in removing these crusts: so I advise you to adopt the wise precepts of Rilliet and Barthez, who said, 'Do not attempt to destroy this scurf when you find that any trouble follows any diminution of the morbid secretion, or if the general health of the child improves as the eruption progresses.' You must also abstain from action if the cutaneous affection has come on after an ophthalmia, or if any eye-trouble follows after the treatment for

removal has commenced. If the porrigo occupies a great extent, do not attack it all at once, but try a part. As a last precept, 'go slow!' in all circumstances.

"The treatment is mostly with emollients or weak astringents, or applications of rice or starch-powder, subnitrate of bismuth, or oxide of zinc, with olive oil. When the concretions have fallen, good effects are obtained with pomades of vaseline, to which may be added tar, tannin, or calomel, one-twentieth part. Sometimes you may try oil of cade, cod-liver oil, or some of the sulphur preparations, looking at the same time to the general health of the young subject.

"But it is by swathing the parts with a rubber cloth that you will do the most good, taking care to take off the envelope as often as twice a day and wash it with a solution of oak-leaves in water. The bandage must not compress the parts, but fit loosely. On the head a cap can be fitted, but it must not fit tightly. The face may have a loose mask. The part affected we wash with an astringent liquid, and the apparatus is kept on night and day. Thus separated from the air and submitted to a uniform temperature, the skin will clean itself promptly usually in seven days."

Cocaine.—The papers and the clinics are wild over this new local anæsthetic, or, as De Wecker calls it, "paralyzer," for he claims that it is on the extreme ramifications of the nerves that it acts. Panas, Landolt, and all the ophthalmologists are actively experimenting with it. Even the dentists have their say, to the effect that they destroy the dental pulp with it, and by its use operate without pain on cavities that are or were exquisitely sensitive. The druggists are also active, and are making all sorts of "pastilles" that they announce as sure cures for all troubles of the larynx, gastralgia, and nervous vomiting. At a meeting of the Paris Société de Chirurgie on December 31, M. Cazin stated that he had used it in a case of vaginitis in which, for that cause, the patient had been unable to have sexual connection for years. The application of a solution of cocaine on the vulva and in the vagina was sufficient to make the hyperæsthesia of the region disappear during the time necessary for coition.

We have now plenty of hydrobromate of cocaine made by a French house.

Dr. Doleris, who has charge of the "*Maison d'Accouchement*," has just told us of some of his experiments with the drug. He has been able to suppress entirely the pain accompanying the dilatation of the cervix, also at the moment of the expulsion of the fœtus, during the last period of confinement, He also obtained a very notable decrease in those perineal pains that are so severe for many women, and without interfering with the normal birth of the child.

M. Paul Bert has also been making some little experiments, and he finds in vesication that all that was needed to entirely suppress the pain was to make an injection into the sac and to cover it with a cloth imbibed with the cocaine. He remarked that the insensibility was not uniform; that it presented itself in the form of little islands, with a sensitive interval between them. It would seem, then, true that it acts on the terminal points of the nerves.

M. Regnard placed a fish in a solution of cocaine, and in a few minutes it seemed to cease to breathe; but it was only a suspension of respiration, as the quantity of oxygen in the water did not vary, and the production of carbonic acid was not noticed. At the end of two hours the fish was put into fresh water and revived.

The new French Surgical Congress, we are informed by Dr. Pozzi, the eminent surgeon of the Lourcine Hospital, will hold its first session in the early part of April, at the Medical School, which will then be vacant for the Easter holidays. Some very interesting subjects will be treated, such as

"What are the Best Means for curing Cold Abscesses?"

"What Indications will the Examination of Urine furnish to Surgical Practice?"

"What are the Best Dressings to Employ in the Army when in the Field?"

"What are the Indications for Operation in Deep Wounds of the Abdomen?"

"The Origin and Nature of Coxalgia."

"Indications for Trepanning in Traumatic Lesions," etc., etc.

A very curious study is being made of the cause of the very high rate of mortality in children in France, which is estimated to have been for some years as high as one hundred thousand a year in all France, or say ten millions in the last hundred years. It is in great part caused by the habit of the French women of all classes in the cities sending their children out into the country to nurse. It is astonishing to strangers in Paris and the large French cities to see so few young children in the streets. For a number of reasons, very few children are brought up in Paris. First is the want of space; then the fact that proprietors of many apartments will not rent them to people who have children. Moreover, it has been the custom for years to send the children out to nurse, and so the "baby-farming" system flourishes here more than anywhere, and is probably principally responsible for the above frightful mortality.

Dr. Germain Sée and Prof. Hardy are having it tooth and nail over the treatment of pneumonia. Dr. Sée claims to have found the bacillus of pneumonia, and calls this form of it "*pneumonie parasitaire.*" His treatment is expectant, and he discards bleeding and all depressing medicines like antimony tartrate. Sée is now giving a series of lectures on asthma, in which he defines as a trinity asthma, emphysema, and chronic catarrh.

The following is a list of the principal recent papers and works of some of the most prominent French doctors, and it will show their present line of thought:

Sappey.—"Effects of the Experimental Lesion of Peduncles of the Brain."

Ball.—"Prolonged Dreams."

Dujardin-Beaumetz.—"Intestinal Antiseptic Medication."

Hardy.—"Broncho-Pneumonia and Commencing Tuberculosis."

Tripier.—"Deviations of Cardiac Rhythm associated with Epilepsy."

Vulpian.—"Tabes Dorsalis."

Trélat.—"On the Value of Plastic Operations of the Palate, and the Age when they should be attempted."

Doleris.—"Embryotomy with the Hook and Cord. Recommended by Dr. Pajot."

Terrier.—"Clinical Remarks on a Third Series of Twenty-five Ovariotomies."

Guéneau de Mussy.—"Study of the Hygiene of Moses and the Ancient Israelites."

Germain Sée.—"*Pneumonie parasitaire*, Acute Bronchitis, Gangrene, Cancer, and Hydatids of the Lungs."

Fournier.—"Lessons on Tabes of Syphilitic Origin."

Jaccoud.—"Medical Lessons at La Pitié Hospital."

Galezowski.—"Diagnosis and Treatment of Ocular Affections."

Gosselin.—"Letter on the Treatment of Hæmatocele."

Panas.—"Local Anæsthesia of the Eye with Cocaine."

Gallard.—"Clinical Lessons on Menstruation and its Troubles."

Siredey.—"On the Diagnosis of Typhoid Fever in the First Stage."

Auvard.—"Corrosive Sublimate in Obstetrics."

Medical Study in Paris.—A few words on the opportunity for observation and study in Paris may not come amiss. While there is a good deal of feeling among French students against foreigners, which they lately showed by a long series of letters to the papers and in signing petitions to the Minister of Public Instruction, still the professors and all the hospital doctors are very courteous, and they willingly show a stranger all over their wards and explain all the cases. The students seemed incensed particularly at the ease with which up to the present quite a large number of women who are of Russian nationality have obtained permission to enter the Medical School without first obtaining the French degrees of Bachelor of Arts and Sciences, as they (the French) are compelled to do. This has been accorded to most foreigners, but is now refused to many unless they can show diplomas of study equal to those of the French students. The women, too, had applied to be admitted as *internes* to the hospitals, where they are already allowed as *externes;* but this is strenuously opposed. All this does not amount to much except to those who may wish to obtain the French diploma, which will now not be given unless the candidate passes all the examinations, eleven in all, commencing with botany, zoology, and chemistry, and going all through the other branches, with two practical proofs of operative ability on the cadaver, one of dissection and the other of amputation. This is the difficult side of it now. For the nice side of Paris study, any one who has a wish to study here can have more for nothing in the way of practical medicine and surgery than anywhere else in the world.

There are over twenty hospitals in which every morning you can enter without fee of any kind, and follow the doctor from bed to bed, and see the patients, examine them, and hear his treatment. This from 8 to 10 A.M. Then at 10 you may attend a clinic, either medical or surgical, and see the best professors perform operations. You may then go into the consulting-rooms and see the treatment given to those poor people who attend them; all this without fees. This will take all the morning. Then in the afternoon you may go to the Medical School and attend all the lectures without any charge. All are welcome who choose to enter. Should you wish to attend any of the practical laboratories of chemistry, physics, pathological anatomy, etc., or dissections, the fee is eight dollars for the year. The new dissection-rooms in Paris consist of eight large buildings that have just been built and opened this winter. They have been built of white stone, are very lofty, and "material" is plenty, some two hundred cadavers on the tables all the time. This course is from 12 noon to 4 P.M., a lecture being given from 12 to 1, or 1 to 2, in each building, by one of the eight "Prosectors." Eight dollars, or forty francs, will admit any doctor to all this. In regard to obstetrics, there is at least *one birth daily* at the Faculty's "*Maison d'Accouchement*," at which you may "assist" gratis. This also occurs in three of the hospitals. There are quite a number of outside lessons (private), given by the younger professors for about twenty to thirty dollars a course. A knowledge of French is of great importance to take advantage properly of all that is given away; but at the same time one who only wants to see and make his own diagnosis can visit a few hundred different kinds of "*malades*" every day and see the operations done without any charge. This is spoiled a little by the fact that living is dear in Paris. Even in the "Latin Quarter" you will not be able to live, and poorly at that, under ten to fifteen dollars a week. The lowest board per month is forty dollars.

The actual number of students entered on the books at the medical school here is four thousand, of whom five hundred and thirty-

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eight are foreigners, mostly Russians, Poles, Roumanians, and Serbs, and a few Spaniards and South Americans; only two or three English and Americans (United States). The number of women admitted this year is seventy-eight, of whom only thirteen are French, the rest mostly Russians and Poles, one American. No difference is made between the male and female students. You will see two women and three men often assigned to dissect one male or female subject, just as it happens. One can also see a woman do a post-mortem on a male subject. The women-students are assigned to and visit the male wards, and "assist" at all the operations, including catheterization.

J. LINN, M.D.

PARIS, January 24, 1885.

PROCEEDINGS OF SOCIETIES.

MEDICAL SOCIETY OF THE COUNTY OF NEW YORK.

A STATED meeting was held January 26, 1885, DANIEL LEWIS, M.D., President, in the chair.

AFFECTIONS OF THE EAR INFLUENCED BY OR DEPENDENT ON MALARIA AND DEFECTIVE DRAINAGE.

Dr. O. D. POMEROY read a paper with this title, and said that the question was one which was beset with difficulties, the chief difficulty being to determine to what extent the symptoms might be due to malaria or to quinine. He quoted extensively from authors who had reported cases of ear-disease of supposed malarial origin, including the names of Weber Liel, Hotz, Voltolini, and others. In some of the cases bad house-drainage evidently played an important rôle in the etiology or continuation of the disease. The symptoms usually consisted of chills and fever of an intermittent type, of tinnitus aurium, etc. Weber Liel said that in the treatment quinine alone in large doses gave relief, and the earlier it was prescribed the more thorough and rapid would be its action. A change of air had effected a cure in some instances when all other means had failed. Dr. Pomeroy related the case of a man whom he saw at the Manhattan Eye and Ear Hospital, in 1883, who had lived in a malarious district, and whose ear-symptoms improved under the administration of quinine, although the discharge from the meatus did not cease until after local applications of a solution of nitrate of silver.

In order to determine as far as possible the influence of malaria in the production of ear-affections, he had sent interrogatories to thirty-six different aural surgeons in the United States and Canada, to which he had received replies from twenty-eight, including the names of Miller, Blake, Seely, Theobald, Burnett, Holmes, Jones, etc. Most of these gentlemen did not give credence to the belief that ear-diseases might be directly dependent upon malarial poisoning, although not a few had seen cases in which the aural affections were aggravated by malaria or bad drainage.

In conclusion, Dr. Pomeroy expressed the opinion that malaria and bad hygienic surroundings, including defective house-drainage, exerted a modifying influence on ear-affections, but he could not accept the view expressed by Weber Liel, Hotz, and Voltolini, who described cases of ear-disease caused by malaria.

DISCUSSION.

Dr. HACKLEY opened the discussion, and said he thought we might perhaps have gained some information from the homœopaths with regard to the influence of malaria upon ear-affections unmodified by the effects of quinine, for cases treated by their methods, it was supposed, ran a more natural course. He himself was in the habit of administering quinine in cases in which ear-disease was complicated by malaria. As to the occurrence of aural troubles from malarial poisoning, he supposed it would probably depend indirectly upon different states: first, upon pharyngeal trouble extending to the Eustachian tubes; second, upon so-called vaso-motor disturbances; and, probably, upon affections of the internal organ of hearing arising through changes in the vaso-motor condition. But quinine and malaria were so badly mixed up in the cases of ear-trouble which he had seen that might have a bearing upon the question under consideration, that he was unable to say which had exerted the more important influence.

Dr. SIMON BARUCH would enter a protest against the increasing tendency to attribute all simple, as well as complicated, pathological conditions to malaria as the chief etiological factor. That there were any cases of malarial ear-disease he regarded as extremely problematical. He had resided in a malarial district for twenty-five years, and never before had he heard of ear-disease being attributed to malarial poisoning. He felt sure that in the cases whose histories were read by the author of the paper there must have been some hidden error. Although many diseases had been ascribed to malaria, standard authorities had failed to recognize any of the pseudo-malarial affections as due to malaria, and in this way they had refused to shield those careless diagnosticians who took malaria as a text for every slip in their diagnosis. He quoted from the statistics of the Board of Health of New York, showing that a much larger proportion of deaths from malaria were reported than would be recognized by any authority. There must therefore have been a large number of errors in diagnosis.

Because benefit had been derived from quinine in certain cases of ear-trouble it did not prove that they were due to malaria. In reviewing the cases reported by Weber Liel, Hotz, Voltolini, Pomeroy, and others, he thought he could find very positive evidence that the cause of the ear-affection was not malaria, although malaria coexisted in some of the cases.

Dr. JOHN C. PETERS had had several attacks of fever and ague years ago, and in the first attack, when he was taking no quinine at all, the most troublesome symptom was tinnitus aurium. He also referred to the case of a lady in whom the ear-trouble was evidently due to bad house-drainage, and recovery took place after the administration of quinine. Dr. Baruch had said that cases of malaria were reported in New York in midwinter, and cast doubt upon the diagnosis because the best authorities had stated that it could not exist when the temperature fell below a certain point. Dr. Peters would call attention to the fact that water and bad drainage existed under many of the houses and streets in New York during the entire year, and consequently, if the houses were kept warm, malaria was liable to develop. There were not a few cases of mixed malaria; that is, of disease due to the combined influence of bad drainage and malaria. He thought that after Dr. Baruch shall have lived in New York as long as had some of the older residents at the present day, he would be less sceptical with regard to the large number of cases of malaria in this city.

Dr. HOLCOMBE did not know that he had, during over twenty-five years' experience in ear-diseases, ever seen a case in which the aural affection could be attributed directly to malaria. He thought malarial and aural affections happening in the same patient at the same time might be misleading, especially if we were disposed to accept the view that there were really cases of malarial otitis. He remembered that once, in conversation with Ricord, the latter was asked if he had ever known a case of syphilis to be cured. He replied that he had now been in practice about fifty years, and, while he could not say whether any of his cases had really been cured, he hoped to live long enough to be able to answer the question positively. So it was in malaria and ear-affections. The patients might have relapses, and it was difficult to say just how much the aural trouble might be due to malaria or bad drainage.

Dr. POMEROY, in closing the discussion, said he had been very careful not to bring theory into the consideration of the question. He had all the time been in the position of the investigator having but one interrogation-point before him, and that was, What is the truth? He had refrained from expressing an opinion. He thought he had wisely put into the title of his paper, "due to malaria or bad drainage," and not alone "to malaria;" and we were able to dodge around a good deal with that amount of latitude. It might be said that in many of the cases quoted there was a history of dampness about the dwellings, and there was an active cause of catarrh, and catarrhs with reduced health favored ear-affections. He did not believe that malaria would ever be put down as the direct cause of typical otitis. We might say, however, that inflammatory affections of the ear might be aggravated, in an indirect way perhaps, by malaria and sewer-gas. We might certainly say that painful affections of the ear were often aggravated, sometimes perhaps almost excited, by malaria and sewer-gas influences. But the question was a mixed one, and it seemed impossible thoroughly to unravel it.

THE MANURE NUISANCE.

Dr. A. HADDEN, of the Committee on Hygiene, reported concerning the manure-dumps along the East River front. Formerly the odor given off by these piles of decaying manure filled the atmosphere for more than a mile around. The question had arisen in the minds of many whether they were truly nuisances and detrimental to the health. Professors Chandler, Doremus, Draper, and others, had said the air was unhealthy to inspire, and the committee thought it was beyond a doubt but what they rendered the neighborhood insalubrious, although they hesitated to commit themselves to the belief that they might give rise to any specific form of disease. The manure was now being removed as fast as the present methods would permit.

Another nuisance was the periodical removal of the manure from the pit at the stable, which rendered the atmosphere of the neighborhood offensive. Several plans had been suggested for lessening the nuisance: one was to wash the material and use the straw for making paper; a second, to destroy it by rapid combustion; and a third, to compress it within barrels at the stables. The latter method seemed to the committee the most practical, and it had been adopted by certain of the stables in the city with excellent results. The manure so packed remained odorless and not detrimental to the health for a very considerable period of time. The method was by no means new, having been advocated by the public press years ago.

The conclusions at which the committee had arrived were, that the manure-dumps of this city were nuisances and highly detrimental to the public health, and all reasonable means should be used to entirely do away with them, and they recommended to the Society to insist upon the health officers adopting some feasible method, whether those suggested or others, to lessen the nuisance or to entirely do away with it.

Dr. JOHN C. PETERS said he had paid a visit to the manure-dumps that day, and the smell which he encountered was something to be remembered. What added to the offensiveness of the atmosphere was a sewer which carried the refuse of slaughter-houses, a fat-rendering establishment, besides other filth. It might be added, he said, that one of the largest oleomargarine-manufactories in the city was situated in close proximity to the mouth of this sewer, and received the full benefit of its sweet perfumes.

The report of the committee was accepted.

The ability of members, who proposed to continue to practise medicine, to resign from the county societies was doubted, and a motion was adopted requiring the *comitia minora* to report whether the law of 1880 repealed that of 1828, by which all legal practitioners had to be members of the county societies.

NEW YORK ACADEMY OF MEDICINE.

STATED meeting, February 5, 1885. The meeting was called to order by the retiring President, FORDYCE BARKER, M.D., LL.D., who introduced the following-named gentlemen occupying seats upon the platform: Dr. Parvin and Dr. S. Weir Mitchell, of Philadelphia; Dr. Shutuck and Dr. Chadwick, of Boston; Dr. Billings, of the U. S. Army; and ex-president Dr. Anderson.

On motion of Dr. C. R. AGNEW, an invitation was extended to Prof. Merriam, of the Columbia College, to lecture before the Academy, on the "Temple of Æsculapius."

Dr. BARKER then read his

RETIRING ADDRESS,

in which he said he would briefly recall the more prominent features in the history of the Academy during the period of his connection with it as presiding officer, and would make some suggestions relating to its future growth.

Since his connection with the Academy it had acquired a new and commodious hall, largely through the munificent donation of Dr. Abraham DuBois. But they were fast outgrowing this hall, as the library was nearly full, and had gained since 1879 about twenty thousand bound volumes and six thousand pamphlets. The circulating department contains about six thousand volumes. In the journal-room are between two and three hundred medical journals in all languages in which there is to be found a medical literature. The Academy was greatly indebted to Messrs. Wood & Co. and Messrs. Appleton & Co. for large donations of their new publications, and he suggested that it would be profitable for both authors and publishers to give to the Academy a volume of each of their new works.

The Academy had absorbed another very important organization,—The Medical Journal Association. He briefly alluded to the fact that nearly two years ago the Academy passed through the segment of a cyclone, and yet during the past year it had approached more nearly its avowed aims and high purposes than during any former year since it was founded. Four times as many papers had been offered as there were sessions at which to read them. The discussions on the papers had been chiefly by those familiar with the subject and specially prepared to make remarks, and thus the time of those present at the meeting was not wearily wasted in listening to crude, profitless, and digressive talk.

It was thought that the mortgage on the Academy of five thousand dollars would soon be raised. The Sections of the Society, with the exception of that on Obstetrics and Diseases of Women and Children, had not, it was to be regretted, done any scientific work. He hoped the time would soon come when the Academy could offer a home, free from expense, to such societies as the County Medical, the Pathological, etc.

The standing committees, with the exception of that on Medical Education, had faithfully discharged their duties. He thought the time was now ripe for the Committee on Medical Education to do important work towards the elevation of the standard of medical education. In this connection he referred to the subject of a State board of medical examiners, and asked if the demands of the most progressive members of the profession would not be satisfied if the Committee on Education of the Academy of Medicine were made a supervisory board of examiners for the medical colleges of this city. He then said that none but those who were well acquainted with the facts could appreciate the great advance which the medical colleges of New York had made during the past quarter of a century in teaching and in their facilities for imparting a thorough education in all departments of medicine. He also alluded in terms of highest praise to the good work done by the polyclinics of the city.

Dr. Barker then said that what the Academy requires in the future is a large fire-proof building, including room for a complete medical library, a large hall for its meetings, and others for smaller societies; a large room for a museum illustrating physiological and pathological anthropology, which should include a craniological series, a pathological series, and a series of sections and dissections, illustrating both topographical human anatomy and a comparative anatomical series; an anthropometric laboratory provided with the best means of measuring human bodies, the faculties, and everything cognate to these subjects, which should include a set of psychometrical instruments and everything pertaining to the series; a lecture-hall equipped with apparatus for lectures and demonstra-

tions of all kinds; a thoroughly-educated and trained pathologist, a capable mechanic, and a practical phonographer.

Although this was a broad scheme, the munificent gifts made to medical institutions recently by various wealthy persons gave reasons for hoping that it would be carried out.

ADDRESS OF DR. JACOBI.

Dr. ABRAM JACOBI, the newly-elected President, then took the chair and read an address, in which, after expressing his appreciation of the high honor conferred upon him and making remarks complimentary to the retiring President, he directed attention to some means by which the interests of the Academy might be promoted.

He thought it desirable that, instead of but one or two, all the Sections should begin to put forth some signs of active life. He also thought it desirable that the several medical societies of the city should meet in the halls of the Academy. It was hoped that the older members would not give up their duty in the Academy, thinking that the younger ones should take on their work. They should remember that the young man with wisdom and learning was often anxious to listen to the advanced in age, who had not only wisdom and learning, but also experience. He contrasted the means by which institutions like the Academy of Medicine in this country were supported with the means of support of similar institutions in Europe. Here the man who devoted attention to promoting the advancement of medical learning and the public health by labors in institutions devoted to science had also to keep up an active practice of medicine, a fact which did not permit him to forget the aphorism that the end of all medicine was the promotion of the public health. The time would come, he hoped, when all sanitary laws would bear the evidence of a consultation by our legislators with the medical profession. The President of the Board of Health would in time be chosen by the better part of the profession; indeed, the most improbable of all things would perhaps come to pass,—viz., the public would come to recognize the fact that the government of hospitals was not complete without a medical adviser in their boards.

"Medicine during the Eighteenth Century" constituted the main body of the address, and in his remarks Dr. Jacobi gave France the honor of the first position, which, however, it had since lost, and at the present time Germany stood in advance of all other countries in scientific medicine. It had been said that America had not produced a John Hunter or a Virchow; but all England had produced only one John Hunter, and all Germany only one Virchow. America had, notwithstanding, many names to which she could refer with pride, and not a few of them were associated with the New York Academy of Medicine. It could be said of the American practitioner that he had received, appropriated, and digested the results of foreign scientific labor, to which he had added his own. The state of medicine during the eighteenth century was such as to favor the development of homœopathy and other species of charlatanry which flourished so vigorously during that period. Finally, a school of pathologists sprang up, and this department of medicine so occupied the minds of medical men in Germany that the public were in a position, about the time of Rokitansky, in which they preferred the homœopath's pill-box to the pathologist's post-mortem case.

The time was, or rather now is, when a new theory in pathology could change the entire basis of etiology. It was unnecessary for him to explain that he referred more particularly to bacteriology. In this connection he referred to the pathology of Virchow. It was not his intention to make the present occasion one for eulogizing that eminent man, but he would say he was of opinion that bacteriology had too often to beg the question. His reason for referring to the subject at present was to suggest that the Academy should do its share towards settling the vexed question of the part played by bacteria in the production of disease. It is time, at any rate, that incapable authorities should cease to occupy our time with their discoveries of germs which they claimed to be the sole cause of this, that, or the other disease, but which were only to be replaced by the next coccus that might come along. We were willing to listen to such gentlemen as Koch and his compeers, who could wait until their views and discoveries were matured before they gave expression to them, but fifty thousand beginners in the studies of the microscope, like fifty thousand beginners in playing the piano, might become a noisy nuisance. He then mentioned some of the points of resemblance between the symptoms of chemical poisoning and those of infectious diseases said to be due to a peculiar germ, and expressed the opinion that it had not been by any means definitely proven that any given bacteria were the real cause of particular diseases. He said that he had but recently learned that four years before Semmelweiss had proclaimed the contagious character of puerperal fever it had been taught by our own anatomist, philosopher, poet, and Autocrat, Oliver Wendell Holmes.

In accepting the loving cup from the retiring President, he said an invitation would at another time be extended to the Fellows to participate in its pleasures in a more commodious hall.

Dr. CHADWICK then read a letter, directed to Dr. Barker, from Dr. OLIVER WENDELL HOLMES, who had been invited to be present; after which the Society adjourned.

NEW YORK PATHOLOGICAL SOCIETY.

A STATED meeting was held January 28, 1885, JOHN A. WYETH, M.D., President, in the chair.

ALTERATIONS OF TEMPERATURE DUE TO CEREBRAL LESION.

In the discussion on some specimens presented for candidates for membership, Dr. Seguin inquired of Dr. Janeway whether he regarded the rule of Charcot, concerning the significance of the temperature after cerebral hemorrhage, as true in practice.

Dr. JANEWAY replied that patients upon whom he had sought to test the rule had recovered, and he had consequently been unable to determine whether the symptoms had been due to hemorrhage or some other lesion within the cranium.

Dr. SEGUIN had not doubted the practical value of Charcot's statement until recently he had a patient who became affected with hemiplegia and aphasia, and it was found the temperature at first was depressed and afterwards elevated. Diagnosis of cerebral hemorrhage was made. The patient improved, but subsequently had another attack which ended fatally. Much to his surprise, he found at the autopsy thrombosis of the middle cerebral artery due to syphilitic endarteritis, and no hemorrhage.

MYXO-SARCOMA OF THE THUMB.

Dr. T. MITCHELL PRUDDEN presented the thumb of a man about 65 years of age, which had been removed for myxo-sarcoma, which had developed after the member had been stung by a wasp.

SALIVARY CALCULUS OF STENO'S DUCT.

Dr. E. C. SEGUIN presented a specimen obtained from a gentleman who was under treatment for specific hemiplegia. He was now in good general health; but a few days ago, without any apparent cause, the cheek began to swell in front of the parotid gland, and there was also swelling to be seen about the orifice of Steno's duct, from which a profuse amount of mucous fluid escaped. The next morning the patient found the calculus presented lying between the cheek and jaw, and the duct was diminished in size. A few years ago Dr. Seguin met with a similar case of calculus of Wharton's duct in a lady of gouty diathesis. There was swelling and an abnormal tenderness, and on introducing the probe into Wharton's duct it came in contact with a hard substance. Within a few days the calculus was thrown out spontaneously as in the case just related. It seemed somewhat remarkable that there could be spontaneous extrusion of calculi of so large size.

DIAGNOSIS OF KIDNEY-DISEASE AND PLEURISY.

Dr. BEVERLY ROBINSON presented specimens, and related the history of a case, which illustrated certain points of interest The patient was 44 years of age, and entered St. Luke's Hospital November 26, 1884, having, three days after exposure to wet, been taken with a chill, followed by fever and severe pain upon the right side of the chest. The expectoration became tenacious, and at times was stained with blood. The urine was of a specific gravity of 1013, but was in other respects apparently normal. Over the right lung posteriorly, as high up as the spine of scapula, was bronchial respiration; over the upper portion of the lung were bronchial râles; inspiration was imperfect. Over the base was resonance, but just above it was absolute flatness. The respiratory murmur was exaggerated over the left lung. The patient died on the 28th. At the post-mortem old pleuritic adhesions existed over the right lung. Near the right base was about a pint of purulent fluid. There was chronic diffuse nephritis.

One point of interest in the case related to the apparently normal condition of the urine, with the exception of low specific gravity, while marked kidney-lesions existed. Dr. Robinson said that in his experience this was not of infrequent occurrence. He regarded low specific gravity of the urine continuing for some time as of great diagnostic importance as pointing to chronic renal trouble, and said that one should be suspicious, when it was present, of kidney-disease, although the microscopic or chemical tests were negative.

Another point of interest was the difficulty of differentiating between pneumonia and pleurisy. The text-books, he said, were in error when they laid down as a general rule that in considerable pleuritic effusion there was always diminution and loss of thoracic resonance, or diminution and loss of vocal fremitus. The present case he thought was an exception to that rule. There was increase of vocal resonance and vocal fremitus at the base of the right lung, notwithstanding there was a pint of fluid found post mortem. Within three weeks past a man entered St. Luke's Hospital with increased vocal resonance and fremitus and marked ægophony over the right base, and yet on introducing the hypodermic needle no fluid was found. It was not until the third tapping that he obtained fluid, and then he withdrew a quart. After withdrawal of the fluid there was even less vocal resonance and fremitus than existed before aspiration was performed.

How are such cases to be explained? In the first place, it had been shown that the sound-conducting power of fluids depended to some degree upon their nature, and in some cases, more particularly in those in which the effusion was considerable in quan-

tity and had formed rapidly, the thoracic walls became distended perhaps more in proportion to the compression of the lungs, and in his opinion under these circumstances the thoracic vibrations before the disease would not be so intense as after a certain amount of the effusion had become absorbed.

Dr. JANEWAY remarked that about ten years ago he wrote an article giving some exceptions to the rules generally laid down by medical instructors. He had seen cases in which the vocal fremitus was preserved notwithstanding an increasing amount of fluid in the pleuritic cavity. Again, he had sometimes observed an error in not observing the exact point at which the vocal fremitus changed. He saw no reason why the vocal fremitus should be preserved over fluid unless the chest-walls were more resonant than usual.

As to the difficulty of diagnosticating kidney-lesions by examination of the urine, it was important to exercise care in searching for casts. Again, it was an error to suppose that because a patient had the signs of nephritis he was positively in a dangerous way. He knew of some patients who had carried the evidences of having atrophied kidneys for many years, in one case there having been albumen and casts in the urine for fifteen years. There were some cases of small kidney which troubled one to make the diagnosis because of absence of low specific gravity and increased quantity of the urine. In one instance which he recalled, the patient had gouty symptoms and obscure brain-troubles. Small granular kidneys were found, which had not been suspected. The urine had been examined from time to time, and was never known to be of low specific gravity.

Dr. Janeway was reminded by the President of a case in which a man passed urine containing albumen only after some degree of mental exercise or excitement, or after a bath. At all other times it was free of albumen. Dr. Janeway also recalled a case in which casts existed in the urine only after boxing. Several cases were on record in which temporary albuminuria existed without Bright's disease.

Dr. WALDSTEIN was acquainted with a family free from kidney-disease, in which for three generations temporary albuminuria existed after physical exercise.

ABNORMALITY OF THE BONES OF THE FOREARM.

The PRESIDENT presented a girl about 9 years of age, who was noticed always to carry the hands with the palms downwards, being unable to pronate and supinate them. It was believed on examination that there was fusion of the shafts of the radius and ulna. Dr. Wyeth did not remember that a similar case had been shown to the Society. A sister of the patient was normally developed.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

STATED MEETING, FRIDAY, JANUARY 2, 1885.

The President, R. A. CLEEMANN, M.D., in the chair.

DOUBLE UTERUS AND VAGINA.

DR. WILLIAM GOODELL described a case which had been sent to him on account of pain in the back, various nervous symptoms, and difficult coition. The vagina was double throughout its entire length. Entrance had apparently been effected indifferently on either side of the septum. The cervices were united like the barrels of a double-barrelled gun. There was a slight divergence of the upper third of the fundus. The sound entered three inches into each cavity. The septum vaginæ was divided up to the cervix, and her physician reports great relief to the general symptoms.

Dr. C. MCCLELLAND described a similar case. Pregnancy had progressed to the third month when the case came under his observation. The vaginal septum was complete. The external contour of the cervix was normal, but a thin septum, extending from the os to the fundus, divided the uterine cavity also into two parts. The prominence of the uterus was greater on one side of the abdomen. The sound was not passed. The vaginal septum was divided shortly before labor. A living child was delivered. About the third day after delivery, a mass, apparently of decidua, was thrown off after three or four hours of labor-pains. After involution was complete, sounds were introduced into the uterine cavities, and the handles diverged one and three-fourths inches. A second conception occurred afterwards on the other side of the uterus.

Dr. GOODELL some years ago had under his care a similar case, which he at first diagnosticated as an extra-uterine pregnancy, as he apparently found the uterus empty on passing the sound into it, while undoubted signs of pregnancy existed. The fœtal tumor was larger towards one side of the abdominal cavity, while the uterus was deflected to the other side. He saw the patient every two weeks, and made frequent careful examinations. He sent the patient to the University Hospital and fixed a day for operation. One day, while lecturing on the case, he had his hand on the abdomen of the patient and felt a contraction or a hardening under his hand. This so resembled the action of uterine tissue that he sent the patient to the Preston Retreat for observation. She was afterwards delivered spontaneously.

There was but one cervix, and one os, but there was a uterine septum higher up, dividing the cavity into two parts.

Dr. HARRIS remarked that the observer, in

these cases, is liable to be deceived because the enlargement of the uterus causes it to rotate, the empty half of the uterus admitting the sound in the median line. The uterus, too, is generally poorly developed, as this form of uterus is probably the result of arrest of development, and its thin walls do not give, to the palpating hand, the normal sense of thickness and resistance.

DOUBLE OVARIOTOMY WITH UNUSUAL COMPLICATIONS.

Dr. W. H. PARISH reported the following case. In September, 1884, I saw, in consultation with Dr. M. O'Hara, a lady who had been under his treatment for a number of months. She was 52 years of age, and of exemplary habits. The menopause had been established for a number of years, and she had enjoyed good health until a few months ago. In June, 1884, she noticed for the first time that her abdomen was enlarged. In July she consulted Dr. O'Hara, with symptoms of indigestion. In August the abdomen had become so enlarged as to occasion concern on the part of the patient, and she had submitted to an examination by him. About August 15, Dr. De F. Willard saw her in consultation with the attending physician, whose diagnosis of ovarian tumor was coincided in. On September 6, I saw the patient with Dr. O'Hara, and also diagnosticated ovarian tumor. The physical signs were the usual ones characteristic of ovarian tumor. There was distinct resonance in each flank, and no indication of fluid in the peritoneal cavity. The abdominal distention had become very considerable, occasioning no little interference with respiration, and was associated with slight œdema of the lower extremities and general emaciation. Removal by operation was urged upon the patient, but was positively refused. After the lapse of ten days I again saw her with Dr. O'Hara. The difficulty in respiration had so greatly increased as to prevent sleep except in the semi-erect position. But little nourishment had been taken, and exhaustion had correspondingly increased. In the erect position the pulse was 160 per minute, in recumbency 130. The abdomen measured 45 inches at the umbilicus. Its shape had changed since my previous visit. In the flanks there was distinct bulging, with fluctuation and percussion-dulness. I diagnosticated peritoneal dropsy as a complication of the ovarian cyst. The œdema of the lower extremities had increased. The patient had requested to be tapped, and it was with reluctance that I consented to resort to that measure.

On September 14, with the assistance of Drs. O'Hara and J. B. Roberts, I attempted to diminish the size of the abdomen by tapping the cyst, using for that purpose the ordinary trocar and canula. Only a few drops of thick, gummy substance were obtained. The cyst-contents were too thick, too jelly-like, to run through the canula. But a single puncture was made. The patient now gave her consent to the performance of ovariotomy.

September 16. The patient had been fed and stimulated as her condition demanded or permitted. Pulse 120, respirations 40, temperature 98¾° F. As yet there had been no apparent disturbance from the tapping.

September 17. Pain referred by the patient to the bowels; three movements, probably resulting from indigestion.

September 18. Operation performed. Condition previous to the operation: Pulse 130, respirations 40, temperature 99° F. Tongue dry and brown. Bowels moved twice during the night. Still had pain, supposed by the patient to be in the bowels. There were present Drs. O'Hara, A. H. Smith, J. B. Roberts, and McElroy. The patient was etherized by Dr. Roberts, and the usual incision along the linea alba was made. The tumor was found to be adherent to the anterior abdominal wall. An attempt was made to break up these adhesions, but the cyst-wall was so extremely thin that the cyst was soon torn. Its contents were too gummy to flow, and it was necessary to scoop out this substance with the hand. The contents had the consistence and appearance of calf's-foot jelly, and was adhesive like mucilage, sticking to the hand so that it was necessary to strip it from one hand with the other. There were numerous slight adhesions to the intestines, but, as the cyst-wall was so extremely thin, these adhesions were not troublesome, portions of the cyst-wall being left attached to the intestines. It was soon discovered that the cyst-wall had ruptured prior to the operation, and that every portion of the peritoneal cavity contained quantities of the colloid material and masses of dark, grumous blood. The contents had doubtless escaped gradually from a rent in the upper posterior portion of the cyst several days before the tapping. It was the presence of this material in the peritoneal cavity that led me to the diagnosis of the coexistence of peritoneal dropsy. There was no serum in the peritoneal cavity. Washing the peritoneal surface with water would not remove the colloid material, and it became necessary with hand and sponge to remove it from the under surface of the liver, from about the spleen and kidneys, as well as from among the intestines. After emptying the large tumor, it was discovered that there was a smaller one, about the size of a fœtal head, unbroken and without adhesions, and partly pressed into the pelvis by the superincumbent large one. The two tumors presented the same characteristics. They had thin, transparent walls, with numerous internal alveoli and thin septa, with gummy, colloid contents. About the base of each, but especially of the larger, there was a lim-

ited amount of solid substance. The pedicle of each was ligatured and dropped into the abdomen. Each tumor evidently grew from an ovary. The general peritoneum; wherever it could be seen or felt, presented innumerable cysts with walls and contents like those of the ovarian cysts. These peritoneal cysts varied in size from that of a millet-seed to that of a pea. Many of the larger ones were ruptured by the hand or sponge. These minute cysts were not aggregated in clusters with stem-like attachments to the peritoneum, but were isolated and had the appearance of blebs on the peritoneal surface. The peritoneum presented general injection of its capillaries, with slight roughening of its surface, but there were no evidences of active or decided peritonitis. The hemorrhage was but trifling, and but few ligatures were applied. The abdominal incision extended about an inch above the umbilicus. A glass drainage-tube was introduced at the lower angle of the wound, and the remainder of the incision was closed with silver sutures.

At the close of the operation the shock was not great, pulse 134. Morphine was given, and the patient passed a somewhat comfortable night. No vomiting.

19th. *Morning.* Pulse 138, respirations 34, temperature 100° F. *Evening.* Pulse 140, respirations 30, temperature 102° F. Vomiting a little, and abdomen somewhat distended. Face pale and features pinched. Three ounces of pinkish serum from tube. Vomiting checked by swallows of hot water and a mixture containing creasote and sodii bicarb. Tube washed out with carbolized water.

The *third night* was restless, with vomiting. Next morning, pulse 150, respirations 26, temperature 101¾°. Increased stimulants, and at noon pulse was 138, respirations 26, temperature 100⅗°.

Fourth night. Slept some, less vomiting. She took koumiss and retained it.

Next morning. Pulse 140, respirations 20, temperature 100 4/10°.

Fifth night. Pulse 120, respirations 22, temperature 101⅘°, stronger. Three ounces of a somewhat offensive fluid were taken from the tube; bowels were moved spontaneously.

Sixth night. She slept well. Pulse 114, respirations 23, temperature 101⅕°. Sutures removed, union complete. Tube slipped out and could not be again introduced. It left a canal with healthy granulating walls.

Seventh night. Vomiting returned. She did not receive the usual amount of stimulants during the night. Exhaustion and vomiting increased without additional rise of temperature, and she died on the ninth day.

The death was doubtless due to exhaustion. The disease of the ovaries and of the peritoneum was doubtless colloid cancer. The tumors and the material removed from the peritoneal cavity weighed fifty pounds. It seems right to conclude that, had the tumors been removed in their earlier stages, the patient would have most probably recovered from the operation and have remained exempt from the disease for months or years, or perhaps permanently.

Dr. MONTGOMERY spoke of the advantages of early operation before peritoneal involvement. He also alluded to the dangers of tapping. He gave a short history of a case of ovariotomy with colloid contents and recovery from the operation, but followed by death six weeks later from cellulitis and ascites, the cause being unknown.

Dr. BAER related a somewhat similar case, in which the patient recovered, but is now apparently dying from a recurrence of the disease in the upper part of the abdomen.

Dr. PARISH, in closing, said that the tapping was done with reluctance, but did no harm in this case. The peritoneal complication made the case hopeless.

OFFICERS FOR 1885.

President.—B. F. Baer, M.D.

Vice-Presidents.—E. E. Montgomery, M.D., W. H. Parish, M.D.

Secretary.—W. H. H. Githens, M.D.

Treasurer.—Alfred Whelen, M.D.

Librarian and Curator.—T. Hewson Bradford, M.D.

Council.—William Goodell, M.D., R. P. Harris, M.D., T. M. Drysdale, M.D., L. D. Harlow, M.D.

Publication Committee.—J. H. Packard, M.D., B. F. Baer, M.D., J. C. Da Costa, M.D., J. B. Walker, M.D.

Library Committee. — Horace Williams, M.D., D. Murray Cheston, M.D.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

A STATED meeting was held at the Hall of the College of Physicians, January 21, Dr. R. J. Levis, President of the Society, in the chair.

The following report was received from the Committee on Hygiene and the Relations of the Profession to the Public:

THE MEANS TO BE TAKEN TO PREVENT THE SPREAD OF CHOLERA IN THIS CITY.

Modern research points to a living organism as the cause of epidemic cholera, a microscopic germ which enters the stomach of one attacked by the disease through the mouth and multiplies in the intestines, whence its progeny passes out with the stools, perhaps sometimes also with the vomit, but in no other way.

Cholera, therefore, must needs pass from one locality to another through the transfer of an individual sick with the disease, who distributes *per anum* and perhaps *per os*

the morbific germs, or the poison is carried in clothing or other stuffs soiled by the discharges from such an individual.

Further, it is believed that the cholera-germ can live and multiply for a certain time outside the body in the presence of decaying organic matter, especially that of animal origin.

Granting these premises, the direction to be taken to "stamp out" cholera is clear and unequivocal: strict attention to details alone remains to make success complete. A person stricken with cholera must be isolated and the germs killed as soon as possible after they leave his body; while, to make assurance doubly sure, the conditions for their living without the body must be eliminated.

The measures to be taken to accomplish the latter purpose will be considered first, since they may be resorted to first in order of time, before the disease has actually made its appearance in a given locality. They involve the removal of all decaying matters, whether vegetable or animal, so disposed as to contaminate the neighboring air or water. Here there will be occasion for much acumen and ingenuity in discovering hidden filth. Obviously, privies and cesspools must be cleaned thoroughly and disinfected; such disinfection may be accomplished by pouring down, for instance, several gallons of a solution of sulphate of iron (copperas), made of the strength of two pounds of the salt to a gallon of water. The plumbing of houses must be overhauled, to see that pipes are clean and traps secure. All refuse must be thoroughly removed from cellars, closets, garrets, stables, and back-yards; the whole house well scoured and freely ventilated.

Such details as these come under the ken of the householder and are to be looked after by him; but the municipal authorities have their part to do also in the frequent cleaning of streets, alleys, market-places, gutters, sewers, and docks; in the purification of the water-supply, and in the inspection of food, especially to prevent the sale of rotting and decayed vegetables and fruit.

Some sanitarians believe that with these and similar points thoroughly attended to, and nothing more, we might laugh at the approach of cholera in conscious security. But practically all these details will not be looked after: some will escape notice or be carelessly treated. Fortunately, there are other resources to call to our aid, especially when the cholera-germ actually manifests itself: the repressive means first spoken of, the isolation of the patient, and the immediate destruction of the germs after they have left his body. The destruction may be accomplished by receiving the dejections in a vessel containing some germicide, as, for example, a solution of bichloride of mercury (corrosive sublimate) in water, of the strength of two parts of the mercurial preparation to one thousand of the water, the depth of the liquid in the vessel to be two inches. The solution will be better if common salt is mixed with it in the same proportion as the corrosive chloride. It will be well to stir up the whole mass together and to leave the constituents some time in contact,—of course, outside the house. All soiled or even suspected clothing or other material about the patient must be soaked for some hours in another portion of the germicide solution, and afterwards boiled for further precaution. Or the dejecta may be destroyed by heat, as in the following plan: a sheet of paper is placed in the vessel to be used as a receptacle and covered with a layer of saw-dust; upon this the stools are to be received. Immediately afterwards a handful of powdered sulphur is thrown over the mass and the whole at once consigned to the fire.

Yet, with all these attempts at purification of surroundings and designs on the death of the wily microbe, some pertinaceous representatives may be in hiding to do their mischief upon the unwary. These must be circumvented by guarding well our mouths, the avenue by which, we have seen, the enemy enters the citadel. Be careful to drink no water from wells, springs, streams, or rivers near habitations and likely to be polluted, and, if doubt exist, boil the water before using it. Have all articles of food thoroughly washed in pure water and the cooking well done.

There is still another line of precaution. Experience has shown that cholera especially affects those who are suffering from disordered digestion, whether the result of mental causes, such as fear, anxiety, despondency, or following the use of irritating ingesta, as highly-seasoned food and especially alcoholic drinks. Therefore immediate correction of digestive disturbances, diarrhœa, etc., is to be recommended. Calmness of mind and temperance in all things should be the rule. Indeed, in the face of a severe epidemic, it would not be out of the way for the authorities to close all eating and drinking places after a certain hour in the day or early in the evening.

Finally, if attending on cholera-patients or in their immediate vicinity, wash the hands from time to time in the corrosive-sublimate solution, since they may have become soiled with the discharges, and the hands are apt unconsciously to find their way to the mouth.

(Signed) RICHARD A. CLEEMANN, M.D., *Chairman.*
J. F. HOLT, M.D.
HORACE Y. EVANS, M.D.
JOHN H. PACKARD, M D.
JAMES FARRAR STONE, M.D.
F. B. HAZEL, M.D.

TREATMENT OF HEMICRANIA.—Where migraine is of a sympatico-spasmodic character, Finkenstein (*Wratsch*) recommends sodium salicylate, thirty grains, repeated in half an hour.—*Jour. of Nervous and Mental Diseases.*

REVIEWS AND BOOK NOTICES.

THE INTERNATIONAL ENCYCLOPÆDIA OF SURGERY. A Systematic Treatise on the Theory and Practice of Surgery by Authors of Various Nations. Edited by JOHN ASHHURST, Jr., M.D., Professor of Clinical Surgery in the University of Pennsylvania. Illustrated with Chromo-lithographs and Wood-cuts. In Six Volumes. Vol. V. New York, Wm. Wood & Co., 1884.

The fifth volume of this valuable work contains the following sections: Injuries of the Head, contributed by Chas. B. Nancrede, M.D., of Philadelphia; Malformations and Diseases of the Head, by Frederick Treves, F.R.C.S., London; Injuries and Diseases of the Eyes and their Appendages, by E. Williams, M.D., of Cincinnati; Injuries and Diseases of the Ear, by Albert H. Buck, M.D., of New York; Diseases and Injuries of the Nose and its Accessory Sinuses, by Geo. M. Lefferts, M.D., of New York; Injuries and Diseases of the Face, Cheek, and Lips, by Alfred C. Post, M.D., of New York; Injuries and Diseases of the Mouth, Fauces, Tongue, Palate, and Jaws, by Christopher Heath, F.R.C.S., London; Surgery of the Teeth and Adjacent Parts, by Norman W. Kingsley, M.D., D.D.S., New York; Injuries and Diseases of the Neck, by Geo. H. B. Macleod, M.D., F.R.C.S., and F.R.S., of Glasgow; Injuries and Diseases of the Air-Passages, by J. Solis-Cohen, M.D., of Philadelphia; Injuries of the Chest, by Edward H. Bennett, M.D., F.R.C.S.I., Dublin; Diseases of the Breast, by Thomas Annandale, F.R.C.S.E., Edinburgh; Injuries and Diseases of the Abdomen, by Henry Morris, F.R.C.S., London; and Hernia, by John Wood, F.R.S., F.R.C.S., London.

The present volume certainly leaves nothing to be desired. The articles are contributed by writers of wide reputation; they are in many cases complete in themselves, giving an admirable summary of the subjects upon which they treat. They are clearly written, and freely illustrated by cuts and chromo-lithographs. We cordially commend this work to the notice of our readers.

ARCHIVES OF OPHTHALMOLOGY. Edited by Dr. H. KNAPP and Dr. C. SCHWEIGGER. Vol. XIII., Nos. 3 and 4. G. P. Putnam's Sons, New York.

Nos. 3 and 4 of vol. xiii. of this journal are issued in one volume of 260 pages. The original articles, nine in number, are as follows: 1. A New Test for Color-Blindness, by Hilbert, of Königsberg. The test is "changeable silk," preferably "the red and green changeable, in which sap-green and purple threads cross at right angles." 2. A Case of Sudden Amaurosis followed by Homonymous Superior Hemianopia, by Dr. Th. Wiethe.* 3. Report of 1420 Cataract Extractions performed by Professor Rothmund, of Munich, by Drs. Everbusch and Rement. This paper is of interest to all cataract-operators, especially the references to after-treatment, antisepsis, etc. 4. Two Cases of Upward Strabismus, by Dr. Holmes, of Chicago. 5. A Case of Prolapse of the Vitreous through a Needle-Puncture of the Cornea, likewise by Dr. Holmes. Both of these papers are of practical merit, being records of rare clinical experiences. 7. A Case of Amblyopia from Menstrual Hemorrhage in Typhoid Fever, by Dr. C. Williams.* 8. Trachoma in the Negro Race, by Dr. J. Minor. Dr. Minor records six cases of trachoma in negroes. This contradicts the idea of the immunity of the negro race as regards this disease. 9. Cocaine and its Use in Ophthalmic and General Surgery, by Dr. H. Knapp.* This paper contains a summary of the literature of cocaine, including a translation of the original paper of Dr. Koller, in which he introduced this drug to the profession. The following 100 pages of the volume are devoted to a very full *résumé* of the progress of ophthalmology during the greater part of 1883.—H.

GLEANINGS FROM EXCHANGES.

AN ACHIEVEMENT OF THE PENNSYLVANIA RAILROAD COMPANY.—In a recent article on "Control of Vision," Dr. Jeffries, of Boston, calls attention to the entire failure in Connecticut and the partial failure in Massachusetts and in England to obtain efficient legislation to compel railroads to discharge employees with visual and aural defects. Dr. William Thomson, of Philadelphia, in a later article in the *Popular Science Monthly*, explains this failure, and shows how the Pennsylvania Railroad, alone of all companies, has succeeded in subjecting its employees to physical tests. The difficulty with attempts at legislation so far has been that the advocates of the tests would compel railway companies to have expensive examinations made by medical men, which examinations would result in a decimation and demoralization of the force. To the Pennsylvania Railroad Company and Professor Thomson belong the credit of devising and putting into practice a scheme by which the tests could be applied quietly, economically, and effectively. Dr. Thomson invented instruments for the examination of the color-sense, and of visual and aural acuteness, which could be used by any intelligent, instructed man. These instruments, together with rules for examining and recording the tests, were put into the charge

* These papers will be referred to in detail in the next report on ophthalmology in the Medical Times.

of instructed lay officials, who made the examinations and sent their reports to the surgical expert. If the latter found evidence of defect, a further opportunity for a more careful and full examination was given to the employee. If still found defective, he was, if possible, placed in some other position where his special defects could do no harm.

The ratio of those defective in color-vision among two thousand examined was four per cent., and that of those otherwise defective in vision or partially deaf was ten per cent. The Pennsylvania Railroad operates five thousand miles of track and employs about fifty thousand men, of whom about ten thousand are dependent upon color-signals for guidance. It may easily be seen, therefore, that it was no small task to attempt to eliminate the defective. Yet it has been successfully accomplished, and the general manager, Mr. Charles E. Pugh, writes in most positive commendation of the good results of the work.

Other railroads are now rapidly following the example of the Pennsylvania Company. They cannot, however, take away from it the great credit due to having so successfully applied a measure which cannot fail to be the means of saving lives and preventing injury. —*The Medical Record.*

MISCELLANY.

MEETING OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK.—The Seventy-ninth Annual Meeting of the State Medical Society of New York, held on the 3d, 4th, and 5th instant, was an unusually successful and harmonious one. The scientific proceedings and discussions appear to have been fully up to the standard, but the usual high pressure was experienced from the overcrowding of the programme. The most important action taken by the Society was the unanimous adoption of the report of the Committee on Legislation, which recommended the passage of an act by the State Legislature creating a State Board of Medical Examiners for the State of New York, containing essentially the same features as the bill prepared by the Medical Jurisprudence Society of this city, which we believe is now before our Legislature. The New York board is to consist of nine members, nominated by the Board of Regents of the University of New York, six to represent the State Society and three to represent other incorporated State societies in proportion to their membership. Of those representing the Society, three must have no connection with medical teaching and three are to be connected with the colleges.

If this bill succeeds in passing the New York Legislature, it will aid us very much in getting a State Board of Medical Examiners for Pennsylvania.

MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA.—This body will hold its thirty-seventh annual session in the city of Scranton, May 27, 28, 29, 1885. As the programme of the meeting must be distributed at least one month prior to the meeting, all who desire to present papers at this session are requested to forward to the undersigned the title and a brief abstract of the same not later than March 15, 1885.

It should be remembered that no volunteer paper is allowed to occupy more than twenty minutes in reading.

WM. B. ATKINSON,
Permanent Secretary.

HOW TO MAKE HOME ATTRACTIVE.—A husband separated from his wife in New Jersey on the ground of cruel treatment, because she sprinkled his underclothing with croton oil in order to keep him from going to the club and induce him to spend his evenings at home. The expedient was so successful that the wife imparted the secret to some other ladies, but the resulting endemic led to discovery of the trick.

NOTES AND QUERIES.

OBITUARY.

EDWIN SAMUEL GAILLARD, M D., LL.D., died on the 2d instant, in New York, after a short illness. He was the editor and proprietor of *Gaillard's Medical Journal*, and previously of the *Richmond and Louisville Medical Journal*, which was started immediately after the war in the city of Richmond, Va. He was born in 1827, and graduated at the University of South Carolina and the South Carolina Medical College Of late years his health was not very good, so that his whole strength was required for his editorial duties. Socially and professionally Dr. Gaillard possessed qualities that commanded esteem and respect; as an editor he was vigorous, aggressive, and able, and was successful in managing the publication of the *Journal*. He resided for a time in Louisville, Ky., before coming to New York, and while in that city was a member of the faculty of two of the colleges of Louisville.

OFFICIAL LIST

OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT U.S. ARMY FROM FEBRUARY 1, 1885, TO FEBRUARY 14, 1885.

TOWN, F. L., MAJOR AND SURGEON.—Granted leave of absence for twenty days. S. O. 14, Department of Texas, February 4, 1885.

WATERS, WILLIAM E., MAJOR AND SURGEON.—Granted leave of absence for one month. S. O. 24, Department of the East, January 31, 1885.

WILSON, WILLIAM J., CAPTAIN AND ASSISTANT-SURGEON.—Ordered for duty as post-surgeon. F rt Preble, Maine. S. O. 27, Department of the East, February 5, 1885.

WOODRUFF, EZRA, CAPTAIN AND ASSISTANT-SURGEON.—Ordered from Willet's Point, New York Harbor, to Department of Dakota.

TAYLOR, MARCUS E., CAPTAIN AND ASSISTANT-SURGEON.—Ordered to Department of the Missouri. S. O. 30, A. G. O., February 5, 1885.

ROBINSON, S. Q., CAPTAIN AND ASSISTANT-SURGEON.—From Portland, Oregon, to his proper station, Fort Spokane, Washington Territory. S. O. 20, Department of the Columbia, February 2, 1885.